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No. _____

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1994

EQUICOR, INC.,
Petitioner,
v.
LORDMANN ENTERPRISES, INC.,
Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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May 2, 1995

QUESTION PRESENTED

Does ERISA preempt state law tort claims brought by a health care provider against an ERISA benefits administrator, when the conduct alleged to be tortious occurred in the performance of the administrator's duties as an ERISA plan fiduciary?

PARTIES TO THE PROCEEDING

In addition to the named parties, petitioner states pursuant to Sup. Ct. R. 29.1 that CIGNA Corporation is the parent company of petitioner.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit (COX, Circuit Judge; MORGAN Senior Circuit Judge; and COLLIER, District Judge for the Northern District of Florida, sitting by designation) is officially reported at 32 F.3d 1529 (11th Cir. 1994) and is set forth in the appendix beginning at page A-1.

The opinion of the United States District Court for the Northern District of Georgia (Forrester, J.), has not been reported and is set forth in the appendix beginning at page B-1.

STATEMENT OF JURISDICTION

The decision and judgment of the United States Court of Appeals for the Eleventh Circuit were entered on September 26, 1994. (App. A-1.) Petitioner filed a timely suggestion for rehearing en banc on October 17, 1994. Pursuant to 11th Cir. R. 35-6, the suggestion for rehearing en banc also is considered a petition for rehearing. The petition for rehearing and suggestion for rehearing en banc were denied on February 1, 1995. (App. C-1.) This petition is filed timely and within 90 days of the denial by the Eleventh Circuit of the petition for rehearing. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), is involved in this petition and is reproduced in full in the appendix at page D-1.

STATEMENT OF THE CASE

The issue presented by this petition involves the extent of ERISA preemption of state law under circumstances that are "reenacted each day across the country." Memorial Hospital Systems v. Northbrook Life Insurance Co., 904 F.2d 236, 246 (5th Cir. 1990). Specifically, a medical care provider claims that it rendered medical care based upon allegedly false information provided by the benefits administrator regarding the patient's eligibility for benefits under an employee welfare benefit plan.

Respondent, Lordmann Enterprises, Inc., provided private duty nursing services to Victoria Mitchell, the infant daughter of Paula Rebecca Mitchell. Victoria was born with severe birth defects which necessitated home nursing care after her discharge from the hospital. Ms. Mitchell hired a nurse employed by respondent to provide that care.

Ms. Mitchell and Victoria were eligible participants in an employee welfare benefit plan sponsored by Hi-Fi Buys, Inc., Ms. Mitchell's employer. Under the terms of the plan, Ms. Mitchell and Victoria were entitled to health care benefits provided by a group insurance policy issued by First Equicor Life Insurance Company. Petitioner, Equicor, Inc., administered benefits and claims under the plan.

The plan is an employee welfare benefit plan as defined by ERISA, 29 U.S.C. § 1002(l) and (3). According to the terms of the plan, charges for private duty nursing, such as that provided by respondent, were covered for up to thirty (30) days in a calendar year.

Respondent contends that, after it began providing nursing services to Victoria, its chief executive officer, Susan Marot, had several telephone conversations with Geri Castagno, an employee of petitioner. According to

Ms. Marot, Ms. Castagno represented that respondent's home nursing services would be "paid in full" by the plan.

Ms. Castagno admits that she spoke to Ms. Marot but denies that she said anything except that petitioner would pay for the nursing care according to the terms of the plan.

Respondent continued its care for Victoria for approximately six months and thereafter sought payment from petitioner. Petitioner paid respondent all benefits for which it was obligated under the written terms of the plan.

Respondent sued petitioner on July 20, 1992, in the Superior Court of Fulton County, Georgia, seeking to recover $59,432.40, the unpaid balance of its bill for services provided to Victoria Mitchell. Petitioner timely removed the case to the United States District Court for the Northern District of Georgia on August, 20, 1992, on the alternative bases of federal question jurisdiction, 28 U.S.C. § 1331, and diversity jurisdiction, 28 U.S.C. § 1332.

Respondent's complaint, as amended, contained four counts: Count I, brought under Georgia law, asserted a claim for fraudulent misrepresentation; Count II, also brought under Georgia law, asserted a claim for negligent misrepresentation; Count III asserted a claim based on ERISA for benefits under the employee welfare benefit plan; and Count IV asserted a claim based on the federal common law of equitable estoppel. Counts III and IV were asserted by respondent as assignee of Ms. Mitchell's rights under the plan.

On March 1, 1993, petitioner filed a motion for summary judgment as to all four counts, which was granted by the district court on October 2, 1993. (App. B-l.) Respondent timely appealed, and a panel of the Eleventh Circuit Court of Appeals affirmed the grant of summary judgment to petitioner with respect to Counts I, III, and IV. (App. A-1.) However, the Eleventh Circuit reversed the

district court's grant of summary judgment with respect to Count II, concluding that respondent's claim under Georgia law for negligent misrepresentation was not preempted by ERISA.

On February 1, 1995, the Eleventh Circuit denied petitioner's timely suggestion for rehearing en banc, which, under the rules of the Eleventh Circuit, also constituted a petition for rehearing. (App. C-1.) Petitioner now seeks a writ of certiorari to the United States Court of Appeals for the Eleventh Circuit.

REASONS FOR GRANTING THE WRIT

This Court should grant the writ of certiorari for two reasons: First, the opinion of the Eleventh Circuit is in conflict with a decision from the Sixth Circuit Court of Appeals, Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991), cert. dismissed, __ U.S. ___, 113 S. Ct. 2, 120 L.Ed.2d 931 (1992); and second, the extent of ERISA preemption of state law involves an important question of federal law that has not yet been, but should be, settled by this Court.

Section 514(a) of ERISA provides, in pertinent part, that ERISA preempts "any and all State laws insofar as they now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983), the Court interpreted ERISA's preemption provision liberally: "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection

with or reference to such a plan." However, the Court also said that some state laws may affect an ERISA plan "in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Id. at 100 n.21. The Court's statements in Shaw do not provide an analytical framework to determine whether, and under what circumstances, a particular state law either "relates to" an ERISA plan and is preempted, or is "too tenuous, remote, or peripheral" to warrant preemption. As a result, the circuit courts of appeal have reached different results on the precise question raised in this case.

Unfortunately, the circuit courts of appeal employee the conclusory phrases -- "relate to" and "too tenuous, remote, or peripheral" -- instead of a structured analysis of the extent of ERISA preemption. More important, the circuit courts of appeal focus on whether the facts of these cases warrant the existence of a cause of action, rather than

whether the cause of action, if it exists, should be governed exclusively by federal law.

In Memorial Hospital Systems, supra, Hospice of Metro Denver, Inc. v. Group Health Insurance, 944 F.2d 752 (10th Cir. 1991), and The Meadows v. Employers Health Insurance, No. 93-16315 (9th Cir. Feb. 17, 1995), reprinted in 18 E.B.C. 2926, the courts held that state law causes of action asserted by medical care providers did not "relate to" the ERISA plans and were not preempted. On the other hand, in Cromwell, supra, the court concluded that a medical care provider's state law claim of promissory estoppel was preempted. The decision of the Fifth Circuit in Memorial Hospital, followed by the Eleventh Circuit in this case, by the Tenth Circuit in Hospice of Metro Denver, and by the Ninth Circuit in The Meadows, rests upon the relationship between the party plaintiff and the ERISA plan.

Preemption analysis premised on the identity of the party plaintiff is illogical and inconsistent with the ERISA goal of establishing a uniform body of law to govern the conduct of ERISA fiduciaries. In Shaw, supra, the Court quoted approvingly from several passages of ERISA's legislative history which explain the purpose and importance of ERISA's preemption provisions:

> Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

Representative Dent, 120 Cong. Rec. 29197 (1974), quoted in Shaw, 463 U.S. at 99.

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

Senator Williams, id. at 29933, quoted in Shaw, supra at 99.

In Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9-10 (1987), the Court elaborated on the intent of Congress represented by the quoted passages:

> These statements reflect recognition of the administrative realities of employee benefit plans. An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to

guide processing of claims and disbursement of benefits.

We have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements.

The Court concluded:

It is thus clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers

> with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Id. at 11.

Since the purpose of ERISA preemption is to establish a uniform body of law to regulate the duties and conduct of ERISA entities, preemption analysis should focus on the effect the state law would have on the conduct of the ERISA entity as an ERISA entity. If a state law tort cause of action arises because of conduct in which a plan fiduciary engages in fulfilling its ERISA obligations, the state law should be preempted without regard to the identity of the party plaintiff. Otherwise, the plan fiduciary would be subject to varying laws in structuring its conduct. As this Court said

in Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990):

> Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through § 514(a). Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.
>
> Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Unfortunately, the Eleventh Circuit decision in this case, adopting the analysis of the Fifth Circuit in Memorial Hospital, supra, did not analyze Congressional intent with respect to federal preemption. Rather, the decision was premised on two reasons, both of which are concerned with whether a cause of action exists, not whether any such cause of action is governed by federal law. The court's first reason for concluding that there is no federal preemption is based on the following logic:

(1) Congress enacted ERISA to "protect the interests of employees and beneficiaries covered by benefit plans," citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989);

(2) Health care providers must be able to rely on administrators' representations concerning eligibility and coverage;

(3) If health care providers cannot rely on administrators' representations of coverage, medical treatment would be more difficult to obtain;

(4) Thus, preemption of a third-party health care provider's state law claim of misrepresentation would defeat the Congressional purpose of protecting the interests of participants.

The court's conclusion is valid only if it is assumed that federal preemption eliminates the health care provider's ability to rely on communications from plan fiduciaries. And federal preemption would obviate the health care provider's reliance on such communications only if the health care provider had no alternative protection under federal law.

Thus, the real basis for the court's decision is the implicit assumption that health care providers would not have a remedy in the present circumstances if ERISA preempted state law.

The flaw in the court's reasoning is apparent. It simply is not relevant to an analysis of the scope of federal preemption whether, and to what extent, a plaintiff may be left without a remedy. Caterpillar, Inc. v. Williams, 482 U.S. 386, 391 n.4 (1987); see also Avco Corp. v. Machinists, 390 U.S. 557, 561 (1968).

The Eleventh Circuit's second reason for concluding that there was no federal preemption of state law similarly is founded upon a concern that the health care provider would be left without a remedy. The court reasoned:

(1) ERISA does not preempt "run-of-the-mill" claims by non-ERISA entities against ERISA plans, citing Mackey v. Lanier Collections Agency and Service, Inc., 486 U.S. 825, 832-33 (1988);

(2) Health care providers are not parties to the ERISA "bargain," since ERISA does not provide a cause of action for aggrieved health care providers; and

(3) Thus, ERISA a fortiori does not preempt claims by health care providers against a plan fiduciary.

By focusing on the remedy available, the court completely disregarded the effect of applying state substantive law on the administration of an employee benefit plan. Ignoring the effects on plan administration contravenes the principles set forth in Fort Halifax Packing Co., supra, in which the Court held that federal preemption under ERISA is intended to ensure that the administration of a benefit plan will be governed by a single set of regulations.

Additionally, the Eleventh Circuit's concern that health care providers will be left without a remedy under these circumstances is not necessarily correct. Here, the health care provider, as is typically true, obtained an assignment of the participant's rights under the plan before rendering the medical care. Respondent had the right, and exercised it in this case, to bring an action to enforce the

participant's rights under the plan. (Count III of respondent's complaint asserted a claim for benefits under the plan, and Count IV of respondent's complaint asserted a claim based upon the federal common law of equitable estoppel.) Thus, ERISA preemption would not leave the health care provider without a remedy, although it would limit the health care provider to the same remedies available to plan participants. Otherwise, the provider would be afforded greater remedies than could be exercised by the plan participant under the same circumstances.

A plan fiduciary's duty to provide information regarding the existence and extent of coverage under a benefit plan is a duty arising from its obligations as an ERISA entity. Therefore, any alleged breach of that duty should be determined by the uniform body of federal law under ERISA. State law which purports to regulate or to impose liability on the conduct of an ERISA entity arising out of the ERISA

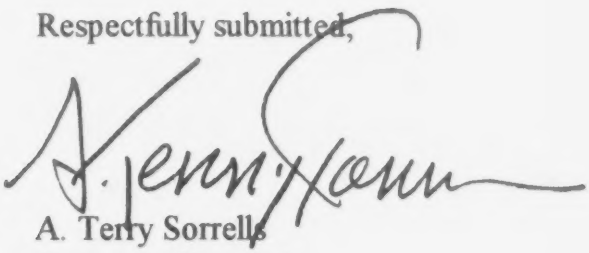
entity's fulfillment of its duties under ERISA should be preempted, without regard to the identity of the party plaintiff. Indeed, the plaintiff in Mackey, supra, was not "a party to the ERISA bargain" but was a collection agency. And, in Mackey, the Court held that plaintiff's cause of action based on a Georgia garnishment statute which singled out ERISA plans for different treatment was preempted. 486 U.S. at 830.

CONCLUSION

Petitioner respectfully urges this Court to grant a writ of certiorari to the United States Court of Appeals for the Eleventh Circuit so that this Court (1) can resolve the conflict between the Sixth Circuit and the Fifth, Ninth, Tenth, and Eleventh Circuit Courts of Appeal, and (2) can clarify the scope and extent of preemption and fill the interstices of the conclusory phrases used in Shaw, supra, between state laws which "relate to" a plan and are preempted and laws which

are "too tenuous, remote, or peripheral" to warrant preemption.

Respectfully submitted,



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APPENDIX A

LORDMANN ENTERPRISES, INC., Plaintiff-Appellant,

v.

EQUICOR, INC., Defendant-Appellee.

No. 93-9271.

United States Court of Appeals, Eleventh Circuit.

September 26, 1994.

Appeal from the United States District Court for the Northern District of Georgia.

Before COX, Circuit Judge, MORGAN, Senior Circuit Judge, and COLLIER*, District Judge.

COX, Circuit Judge:

Lordmann Enterprises, Inc. ("Lordmann"), a home health care provider, sued Equicor, Inc. ("Equicor"), an

*Honorable Lace Alexander Collier, U.S. District Court for the Northern District of Florida, sitting by designation.

insurer under an ERISA[1] plan, that Hi-Fi and Equicor could agree for Equicor to cover plan, to recover charges for nursing care provided to an Equicor insured. Lordmann asserted four different claims, and the district court granted Equicor summary judgment on all four. The significant issue raised on appeal is whether ERISA preempts Lordmann's Georgia law claim of negligent misrepresentation. We hold that it does not. On the other claims, we affirm the district court's grant of summary judgment in favor of Equicor.

I. Background

Paula Rebecca Mitchell ("Mitchell") and her daughter Victoria were provided coverage by a group insurance plan issued by First Equicor Life Insurance Company to Mitchell's employer, Hi-Fi Buys, Inc. ("Hi-Fi"). The defendant Equicor administered the plan. The plan provided coverage for thirty

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[1]Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1988).

days of home nursing care per calendar year. It also provided that Hi-Fi and Equicor could agree for Equicor to cover rehabilitation services not otherwise covered under the plan if an insured became totally disabled because of "severe personal injury," a category that explicitly included neonatal high-risk infants. The First Equicor policy became effective June 1, 1990, and the Mitchells were covered by a policy issued to Hi-Fi by Blue Cross/Blue Shield until that date.

Victoria was born in February 1990 with severe birth defects that required her to spend her first five months in the hospital. After she went home, she needed twelve hours of nursing care a day. Mitchell hired a nurse employed by the plaintiff, Lordmann, to care for Victoria at home. Mitchell then assigned her rights under the insurance plan to Lordmann. The parties dispute the content of the communications that followed between Lordmann and Equicor. Lordmann contends that three weeks after it began

Victoria's care, Susan Marot, Lordmann's chief executive officer, telephoned Equicor to inquire into the extent of Mitchell's coverage under the plan. (R1-18-Ex. 1, Aff. of Susan C. Marot ¶ 9.) Marot spoke to Geri Castagno, an Equicor employee, who informed her that Hi-Fi's group insurance plan would pay 80% of the cost of home nursing. (Id.) A few days later, Castagno approved Lordmann's billing rate. (Id.)

Three months later, Marot again called Castagno to update Equicor on Victoria's condition. (Id. ¶ 10.) Castagno told Marot that she could not find where Hi-Fi's plan provided 80% coverage for Victoria's care, but Castagno informed Marot that Equicor's case management office had authority to alter the plan, and that Castagno would arrange for 100% coverage. (Id.) Lordmann continued to provide nursing care for Victoria. (Id. ¶ 8)

Six weeks later, Castagno called Marot and told her there was a problem with Victoria's coverage. (Id. ¶ 12.) Castagno did not elaborate, but when Marot asked if Lordmann should stop its care, Castagno again said that case management would alter the plan to cover the care. (Id.) Later the same day, Castagno called Marot again and informed her that Mitchell had not returned a case management form Castagno had sent. (Id.) Marot offered to have Mitchell return the form, but Castagno refused and instead told Marot that she was treating the case as if case management had never been involved. (Id.) When Marot asked if she should stop Victoria's care, Castagno again said no, assuring Marot that between Blue Cross/Blue Shield and Equicor, Lordmann's bill would be paid in full. (Id.) During this entire period Equicor monitored Lordmann's care for Victoria. (Id. ¶ 11.) Equicor never informed Lordmann that

the Hi-Fi plan covered only thirty days of home nursing care. (Id. ¶ 13.)

Equicor agrees that Marot spoke to Castagno, but Equicor contends that Castagno informed Marot that Equicor would pay for the services only according to the terms of Hi-Fi's group insurance plan. (R1-17-Ex. 15, Defendant's Response to Plaintiff's First Interrogatories, ¶ 8.)

Lordmann finished its care for Victoria a few weeks later, in early January, 1991, and sought payment from Equicor. In December, 1991, Equicor paid Lordmann $9,952, which was 80% of Lordmann's bill for thirty days of care in 1990 and four days of care (until it ceased) in 1991, less the amount owed by Blue Cross/Blue Shield for the same care. Lordmann also collected $3,425 from Blue Cross/Blue Shield, leaving a balance of $59,432.

Lordmann sued Equicor in state court in Georgia, asserting two claims. Count I is a state law claim based upon

alleged fraudulent misrepresentation. Count II is a state law claim based upon alleged negligent misrepresentations. Equicor removed to federal court, asserting federal question and diversity jurisdiction. After removal, Lordmann amended its complaint to add two federal claims, both asserted as Mitchell's assignee. Count III is an ERISA claim for benefits under the plan, and Count IV is an ERISA claim based upon the federal common law of equitable estoppel. Equicor moved for summary judgment on all four counts.

The district court granted Equicor's motion in full. It held that ERISA preempted the state law fraud and negligent misrepresentation claims. Lordmann Enterprises Inc. v. Equicor, Inc., No. 1:92-CV-2000-JOF, Order at 6 (N.D.Ga. October 2, 1993). The court granted summary judgment on the claim for benefits because it found no dispute over the terms of the plan. First, the plan unambiguously provided 80% coverage for thirty days of home nursing care, and

Equicor had already paid that amount. Id. at 8. Second, although the plan allowed Hi-Fi and Equicor to extend coverage for rehabilitation services to cover Victoria's care, Lordmann had presented no evidence of such an agreement. Id. at 10. Finally, the district court held that the plan provisions were unambiguous, and that under Eleventh Circuit precedent a claim based upon federal common law equitable estoppel is available only in cases involving the interpretation of ambiguous plan provisions. Id. at 11. This appeal follows.

II. Issues and Standard of Review

In this appeal, Lordmann challenges the district court's grant of summary judgment on all four counts. We review grants of summary judgment de novo. Reserve, Ltd v. Town of Longboat Key, 15 F.3d 1374, 1377 (11th Cir. 1994). Summary judgment is appropriate when there are no genuine issues of material fact and the movant is entitled to

judgment as a matter of law. Fed.R.Civ.P. 56(c). The court reviewing the motion must consider all evidence in the light most favorable to the nonmoving party. See United States v. Diebold, Inc., 369 U.S. 654, 655, 82 S. Ct. 993, 994, 8 L.Ed.2d. 176 (1962).

III. Discussion

A. State Law Claims

Lordmann contends on appeal that ERISA does not preempt Counts I and II, its state law claims of fraud and negligent misrepresentation. In response, Equicor argues that ERISA does preempt both claims, and in the alternative, that even if ERISA does not preempt them, summary judgment was appropriate because Lordmann had failed to show it could prevail under Georgia law. We agree with Equicor's state law argument that Lordmann has failed to show all the elements of the fraud claim, but we do not find state law to be dispositive on the negligent misrepresentation claim. Thus,

on that claim we must reach the preemption issue, and we hold that ERISA does not preempt a third-party health care provider's negligent misrepresentation claim against an ERISA plan administrator.

1. Fraud

Equicor contends that summary judgment is appropriate on the fraud claim, even if ERISA does not preempt it, because Lordmann has failed to present any evidence of scienter, a necessary element of fraud under Georgia law. See, Georgia-Pacific Corp. v. Lieberam, 959 F.2d 901, 907 (11th Cir. 1992) (listing elements of fraud under Georgia law). In response, Lordmann argues that under Georgia law scienter may be inferred from surrounding circumstances. McNeil v. Cowart, 186 Ga.App. 411, 367 S.E.2d 291, 293 (1988). However, scienter is not automatically inferable from the fact that the defendant made a misrepresentation. See Shaw v. Cook County Fed. Sav. &

Loan Ass'n, 139 Ga.App. 419, 228 S.E.2d 326, 328 (1976) (mere fact of savings & loan's misrepresentation to borrower that no liens existed on her house not sufficient to support fraud claim). As was the case in Shaw, Lordmann has pointed to no particular facts that could support an inference of scienter in this case. Even under Georgia's lenient standard of proof for scienter, Lordmann has failed to carry its burden on an essential element of its claim. Thus, the district court properly granted summary judgment on Count I. See Celotex Corp. v. Catrett, 477 U.S. 317, 321-23, 106 S. Ct. 2548, 2552, 91 L.Ed.2d 265 (1986).

2. Negligent Misrepresentation

Equicor argues that it is also entitled to summary judgment on the negligent misrepresentation claim because under Georgia law, statements as to the nature of insurance coverage are opinions of law and therefore not actionable for misrepresentation. See Marett Properties, Inc. v. Prudential

Ins. Co., 167 Ga.App. 631, 307 S.E.2d 69, 72 (1983); Parris & Son, Inc. v. Campbell, 128 Ga.App. 165, 196 S.E.2d 334, 337 (1973). However, as Lordmann points out, Georgia courts have expressly refrained from deciding whether this principle would deny recovery for misrepresentation when the plaintiff is neither the insured nor subrogated to the rights of the insured. Home Ins. Co. v. North River Ins. Co., 192 Ga.App. 551, 385 S.E.2d 736, 741 (1989). Because it is possible that Lordmann could prevail on its state law negligent misrepresentation claim, we must determine whether ERISA preempts such a claim.[2]

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[2]The district court did not address the state law claims because it found they were preempted by ERISA. See Lordmann Enterprises, Inc. v. Equicor, Inc., No. 1:92-CV-2000-JOF, Order at 4-6 (N.D. Ga. Oct. 2, 1993). Therefore, we express no opinion on the merits of the state law negligent misrepresentation claim and leave that issue for the district court to consider on remand. See Strength v. Hubert, 854 F.2d 421, 426 (11th Cir. 1988).

ERISA § 514(a) preempts all state laws insofar as they "relate to" any employee benefit plan covered by the Act. 29 U.S.C. § 1144(a) (1988). The parties do not challenge the district court's conclusion that the Hi-Fi group insurance plan is covered by ERISA. See 29 U.S.C. § 1002(1) (1988); Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982). Thus, the question is whether Lordmann's negligent misrepresentation claim "relates to" the group insurance plan. We conclude that it does not.

State law "relates to" an ERISA plan "if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines. Inc., 463 U.S. 85, 96-97, 103 S. Ct. 2890, 2900, 77 L.Ed.2d 490 (1983). However, some state law may affect an ERISA plan in "too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Id. at 100 n. 21, 103 S. Ct. at 2901 n. 21. Based on this Supreme Court interpretation of the statute, both the Fifth

and the Tenth Circuits have found that state law claims brought by health care providers against plan insurers too tenuously affect the ERISA plans to be preempted by the Act. Hospice of Metro Denver, Inc. v. Group Health Ins., 944 F.2d 752 (10th Cir. 1991); Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). We agree.

The Memorial Hospital case presented facts very similar to Lordmann's. In that case, Gloria Echols, a covered dependent under a health insurance policy issued by Northbrook Life Insurance Company, sought care at Memorial Hospital. The hospital telephoned Northbrook Life to verify Echol's coverage, and a Northbrook Life employee confirmed that Echols was covered. The hospital then admitted Echols, who remained in the hospital for two months at a cost of more than $100,000. When the hospital submitted its bill, Northbrook Life informed the hospital of

Echol's ineligibility and denied the claim. Id. at 238. The hospital sued, alleging among other claims a violation of Texas Insurance Code article 21.21, which the court characterized as a Texas codification of negligent misrepresentation. Id. at 244.

The court concluded that ERISA did not preempt the statutory negligent misrepresentation claim for two primary reasons. First, preemption does not serve Congress's purpose for ERISA. Id. at 245. Congress enacted ERISA to protect the interests of employees and beneficiaries covered by benefit plans. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113, 109 S. Ct. 948, 955, 103 L.Ed.2d 80 (1989). Preemption in a third-party health care provider case would defeat rather than promote this goal. The "commercial realities" of the health care industry require that health care providers be able to rely on the insurers' representations as to coverage. Memorial Hospital, 904 F.2d at 246. If ERISA

preempts their potential causes of action for misrepresentation, health care providers can no longer rely as freely and must either deny care or raise fees to protect themselves against the risk of noncoverage. In that event, the employees whom Congress sought to protect would find medical treatment more difficult to obtain. Id. Moreover, in this context disputes do not arise between the health care provider and the insurer under an ERISA plan, but "precisely because there is no ERISA plan coverage." Id.

Second, the Memorial Hospital court reasoned that health care providers were parties beyond ERISA's scope. See id. at 248-49. The Supreme Court has held that ERISA does not preempt "run-of-the-mill" claims by non-ERISA entities against ERISA plans. Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 832-33, 108 S. Ct. 2182, 2186-87, 100 L.Ed.2d 836 (1988), and thus ERISA a fortiori does not preempt claims by health care providers

against a plan fiduciary. Memorial Hosp., 904 F.2d at 249. Moreover, a health care provider's claim against a provider of insurance under the plan affects the relationship between the principal ERISA entities at best only indirectly. Id. at 249. Finally, health care providers were not parties to the ERISA "bargain." Id. at 249. When employers and employees gave up state law causes of action because of ERISA, they received federal causes of action under ERISA in exchange. On the other hand, ERISA does not provide a cause of action for aggrieved health care providers that treat ERISA participants. Id.; see ERISA § 502(a), 29 U.S.C. § 1132(a) (1988 & Supp. IV 1992.)

Finding the Memorial Hospital court's reasoning persuasive, we hold that ERISA does not preempt a health care provider's negligent misrepresentation claim against an insurer under an ERISA plan. We thus reverse the district

court's grant of summary judgment on Count I and remand for further proceedings.

B. Derivative Claims

Lordmann argues that the district court erred in granting summary judgment on its claim as Mitchell's assignee under the Hi-Fi group insurance plan. The plan contains two provisions that Lordmann claims entitle it to payment. The first provides 80% coverage for the first thirty days of home nursing coverage in each calendar year. Lordmann does not dispute that Equicor has paid the amount due under that provision. However, Lordmann insists that it is also entitled to recover as Mitchell's assignee under a term covering rehabilitation services. The plan provides:

> This applies only to a person who: (a) is insured for Health Care Benefits; and (b) while so insured has

suffered a severe personal injury or sickness.[3] If he or she becomes totally disabled due to such injury or sickness, the Employer [Hi-Fi] and the Company [Equicor] may agree that:

1. The Company pay benefits for reasonable and customary charges for rehabilitation services and supplies furnished to such person; and

2. Such benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan . . . . The amount of such benefits will be determined by the Company.

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[3]The plan gives an exclusive list of "severe personal injur[ies] or sickness[es]." "Neonatal high risk infants" appears on the list. (R1-17-Ex.3, Plan Booklet at 16.)

(R1-17-Ex.3, Plan Booklet at 16.) The provision unambiguously requires that Equicor and Hi-Fi agree for the additional benefits to become available. Lordmann argues that Castagno's representations to Marot were sufficient to put in issue the existence of an agreement. We disagree. The provision requires that both Hi-Fi and Equicor agree, and Lordmann has not presented evidence to suggest that Hi-Fi assented to Equicor's coverage of Victoria's care.[4] The district court was therefore correct in granting summary judgment for Equicor on Count III.

C. Equitable Estoppel

ERISA forbids oral modification of plan terms. Nachwalter v. Christie, 805 F.2d 956, 959 (11th Cir. 1986). However, this court has recognized a cause of action for

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[4]We note that the benefit booklet does not define "rehabilitation services," but Equicor has not argued that home nursing care for a newborn is not a "rehabilitation service."

equitable estoppel when a plan administrator makes a representation that interprets, rather than modifies, an ambiguous term of the plan. Alday v. Container Corp., 906 F.2d 660, 666 (11th Cir. 1990), cert. denied, 498 U.S. 1026, 111 S. Ct. 675, 112 L.Ed.2d 668 (1991); Kane v. Aetna Life Ins., 893 F.2d 1283, 1285 (11th Cir.), cert. denied, 498 U.S. 890, 111 S. Ct. 232, 112 L.Ed.2d 192 (1990). Lordmann argues that Castagno's representations were interpretations of the rehabilitative services provision, and that therefore Equicor should be estopped from asserting an alternate interpretation. We disagree.

In Kane, the provision that formed the basis of the administrator's representation was ambiguous.[5] Id. at 1286.

---

[5]In Kane, two terms were at issue. One provided that "[f]ull time employees . . . and their eligible dependents will be covered under he plan . . . on the first day of the months in which the employee will complete a Term of Employment of six (6) months. No benefits are covered for charges incurred during a continuous

(continued...)

The provision Lordmann relies upon to contend that Castagno was interpreting the plan, rather than modifying it, is unambiguous. The rehabilitation services provision clearly requires that Hi-Fi and Equicor agree to extend coverage to long-term rehabilitation services. Lordmann has offered no evidence of any agreement between Hi-Fi and Equicor. Without an agreement under this provision, we must view any

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[5](...continued)
hospital confinement which commenced prior to the effective date of coverage . . . ." Kane, 893 F.2d at 1285-86. Another provided that adopted children became eligible dependents upon the commencement of formal adoption proceedings. Id. at 1284 n. 1. The plaintiff, an employee covered by the plan, had adopted a hospitalized newborn after the insurance plan administrator had assured her that the child's medical care would be covered. After the child was released from the hospital, however, the insurer denied the claim, contending that the child was already hospitalized on the effective date of coverage (the date of adoption). The Kane court found that the provision defining the effective date of coverage could be read two ways, yielding two possible outcomes: an adoptee's coverage could become effective when the employee had worked six months, or an adoptee's coverage could not take effect until the parents instituted formal adoption proceedings. Id. at 1286.

statement made by Equicor concerning the provision as a modification of the plan rather than an interpretation of the extent of an agreement between Hi-Fi and Equicor. Thus, Kane does not apply, and this case falls under Nachwalter's rule against oral modifications of ERISA plans. Summary judgment was appropriate on Count IV.

IV. Conclusion

For the foregoing reasons, we AFFIRM the district court's grant of summary judgment as to Counts I, III, and IV. However, we REVERSE summary judgment as to Count II, the negligent misrepresentation claim, and REMAND for further proceedings.

AFFIRMED in part; REVERSED and REMANDED in part.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

Lordmann Enterprises, Inc.,	)	
	)	
Plaintiff,	)	
	)	CIVIL ACTION NO.
v.	)	
	)	1:92-CV-2000-JOF
Equicor, Inc.,	)	
	)	
Defendant.	)	

ORDER

This matter is before the court on Defendant's motion for summary judgment and Plaintiff's motion for leave to file a reply brief in support of its response to Defendant's motion for summary judgment. Because the court finds Defendant's reply brief attached to its motion for leave to file that brief helpful in resolving Defendant's motion for summary

judgment, Plaintiff's motion for leave to file a reply brief [22-1] is GRANTED.

I. BACKGROUND

Paula Mitchell and her daughter, Victoria, were insured by a group insurance plan issued by First Equicor Life Insurance Company ("First Equicor") to Mitchell's employer, Hi-Fi Buys, Inc. ("Hi-Fi Buys"). Claims were administered by Defendant Equicor, Inc. ("Equicor"). There is no dispute that both Paula and Victoria Mitchell were eligible for benefits under the First Equicor policy.

When Victoria was born on February 18, 1990, she was placed in the neonatal intensive care unit of Grady Hospital, and later moved to the intermediate nursery, where she remained until she went home on July 30, 1990. Victoria suffered from numerous physical problems, which required nursing care twelve hours daily after her discharge. Plaintiff Lordmann Enterprises ("Lordmann") is a provider of home

nursing care services, and Mitchell hired a Lordmann nurse who had cared for Victoria in the hospital to continue with the home health care. Lordmann now is the assignee of Ms. Mitchell's employee benefits under the Hi-Fi Buys Plan.

In late July, the Chief Executive Officer of Lordmann, Susan Marot, contacted Hi-Fi Buys to discuss Mitchell's insurance coverage, and was referred to Equicor's Medical Case Management. Marot spoke with Geri Castagno of Medical Case Management. According to Marot, Castagno informed her that the insurance policy under which Mitchell was covered would provide eighty percent coverage for the nursing care proposed. Marot further states that she spoke with Castagno on October 31, 1990, and was told that Castagno had authority to alter the benefits paid and that she would arrange to have 100% of the charges for nursing care paid. On December 11, 1990, Marot states that Castagno called her and told her that there was a question about

coverage, but that Medical Case Management had authority to alter the plan, and Plaintiff's services rendered would be covered at a 100% rate. Later that day, Castagno called again and again raised some question as to coverage, but stated that Lordmann would need to bill Blue Cross/Blue Shield first and that Equicor would pay the balance, so that Lordmann would be paid 100% for its services rendered. Marot asked during both calls whether she should discontinue the nursing services, and she was told that there was no need to do so. Plaintiff alleges that Medical Case Management monitored the services rendered continuously from July 30, 1990, through January 4, 1991, and that no mention was made during that time of any limitation on coverage for the nursing services.

Equicor alleges that Marot did speak with Castagno, but that Castagno stated only that the nursing services "would be covered under group policy number 72610, or not

covered, subject to the terms and conditions of the contract of insurance."

In December of 1991, Equicor paid Lordmann $9,952.40 and denied the $59,432.40 remaining balance, stating that nursing charges were allowed under the insurance policy for only thirty days. Because Equicor had paid for three days of nursing care earlier in the year, Equicor paid for twenty-seven days of nursing care provided by Lordmann. Equicor further deducted the amount of payments made by Blue Cross/Blue Shield to Lordmann pursuant to a non-duplication provision of the insurance policy.

Plaintiff filed suit seeking damages for Defendant's alleged fraud and negligent misrepresentation (counts I and II) and was granted leave to amend the complaint to add two additional counts seeking payment of the plan benefits based on the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. (count III), and on

ERISA and the federal common law of equitable estoppel (count IV).

Defendant has moved for summary judgment, asserting that counts I and II state no cause of action under Georgia law or, alternatively, that such claims are preempted by ERISA, and that Defendant is entitled to judgment as a matter of law on counts III and IV.

II. DISCUSSION

A. Fraud/Negligent Misrepresentation

Lordmann alleges that Equicor fraudulently or negligently misrepresented to Lordmann that it would be fully paid for all nursing services rendered to Victoria Mitchell, that Lordmann justifiably relied on Equicor's misrepresentation, and that Lordmann was injured as a result of its reliance. Equicor has asserted that Lordmann's allegations do not state a cause of action under Georgia law,

or, alternatively, that Lordmann's state law claims are preempted by ERISA.

The insurance plan provided to Mitchell by Hi-Fi Buys is undisputedly an employee welfare benefit plan subject to ERISA regulation. See 29 U.S.C. § 1002(l) and (3); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987); O'Reilly v. Ceuleers, 912 F.2d 1383, 1387 (11th Cir. 1990); Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982). Section 1144(a) preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA, with certain exceptions, not here relevant, outlined in § 1144(b)(2)(A) and (b)(4).

Consequently, the court must determine whether Lordmann's state law claims of fraudulent or negligent misrepresentation "relate to" the employee benefit plan so as to be preempted by ERISA. "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a

connection with or reference to such a plan." Shaw v. Delta Air Lines Inc., 463 U.S. 85, 96-97 (1983). "[A] state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); Shaw, 463 U.S. at 98. A broad interpretation of "relates to" has been accorded by courts, in order to implement the Congressional intent of protecting employees with a uniform federal law governing their benefit programs. Id. Thus, common law tort and contract actions asserting improper processing of a claim for benefits under an ERISA-governed plan have been held to be preempted. Dedeaux, 481 U.S. 41. Some "run-of-the-mill" state actions may, however, survive. Mackey v. Lanier Collection Agency, 486 U.S. 825 (1988). Here, while Lordmann's common law claims of fraudulent or negligent misrepresentation do not directly implicate the employee benefit plan, they do have a

clear "connection with or reference to such a plan" in this instance. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985). Lordmann, while alternatively claiming to be an assignee of a plan beneficiary, is endeavoring to do that which a beneficiary cannot do under state law, and that is to recover based on alleged oral representation about the coverage of the plan. Assignments of plan benefits to health service providers is not uncommon, and it is not uncommon for those providers to act for the beneficiary on coverage issues. To allow those providers under these circumstances to move against the plan under state law would frustrate a major objective of the preemption doctrine and of ERISA. Consequently, Lordmann's state law claims are preempted by 29 U.S.C. § 1144(a), and this court lacks jurisdiction to adjudicate those claims. Hermann Hospital v. MEBA Medical & Benefit Plan, 959 F.2d 569 (5th Cir. 1992).

B. Count III

Count III of Plaintiff's amended complaint claims that as Mitchell's assignee[1], Lordmann is entitled to payment for all services rendered pursuant to the insurance policy. Lordmann alleges that as the plan's claims administrator, Equicor is a fiduciary within the definition of 29 U.S.C. § 1002(21)(A),[2] responsible for carrying out the duties set forth in 29 U.S.C. § 1104. See Massachusetts Mutual Life

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1It appears that although assignees are not specifically enumerated as having standing to sue under ERISA, such standing generally will be accorded. See, e.g., Kennedy v. Connecticut General Life Ins. Co., 924 F.2d 698 (7th Cir. 1991); Hermann Hospital v. MEBA Medical and Benefits Plan, 845 F.2d 1286, 1287 (5th Cir. 1988); Misic v. Building Service Employee's Health, 789 F.2d 1374, 1377 (9th Cir. 1986); Miami Children's Hospital, Inc. v. Malakoff, 765 F. Supp. 718, 720 (S.D. Fla. 1991).

2Although no evidence has been submitted to prove that Defendant is in fact a fiduciary, Defendant has not challenged that categorization. Therefore, Defendant's status as a fiduciary is assumed for the sake of argument. See Baker v. Big Star Division of Grand Union Co., 893 F.2d 288 (11th Cir. 1989).

Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) (the fiduciary's obligation is to serve the interests of the plan's participants and beneficiaries and "specifically, to provide them with the benefits authorized by the plan.").

Equicor argues that all benefits due under the policy have been paid. According to Defendant, the benefits for at-home nursing care were expressly limited to thirty days per year, the policy provided for eighty percent coverage of the charges, and a "co-insurance" provision would reduce the benefits paid by Defendant in the amount of benefits paid by other insurance companies so that the insured would recover in total no more than the plan's total benefits. After these deductions had taken place, the $9,952.40 paid on December 23, 1991, is the total amount due, according to Equicor. The relevant language of the first EQUICOR-Hi-Fi Buys "Your Group Benefits Plan" booklet-certificate

("booklet") outlining limitations pointed out by Equicor reads:

> WHAT ARE COVERED CHARGES .
> 6. Charges for private nursing made by
> (a) a registered nurse (R.N.).
> (b) a licensed practical nurse (L.P.N.).
> (c) a licensed vocational nurse (L.V.N.).
> Charges for such services done while the person is not confined to a hospital will be covered for up to thirty days in a calendar year.

Booklet, p. 7.

> HOW MUCH
>
> . . . You will be paid at the co-insurance rate shown in the schedule of benefits.

Booklet, p. 9.

> CO-INSURANCE RATE . . . 80%, after satisfying the deductible.

Booklet, p. ii.

> NON-DUPLICATION OF BENEFITS
> If an insured person is entitled to benefits for medical or dental care under this plan and at least one other plan, the amount of benefits provided by this plan for that care

> may be reduced to the extent that the total payment provided for a calendar year by all plans by which the person is covered will not be more than the total of the allowable expenses that the person incurs in the same year.

Booklet, p. 32.

Insurance is a matter of contract, and the rules regarding contract interpretation apply when construing an insurance policy. Richards v. Hanover Ins. Co., 250 Ga. 613, 614, 299 S.E.2d 561 (1983); Barker v. Coastal States Life Ins. Co., 138 Ga. App. 164, 166, 225 S.E.2d 924 (1976); North British and Mercantile Ins. Co. v. Tye, 1 Ga. App. 380, 389, 58 S.E. 110 (1907). "There is no greater sanctity and no more mystery about a contract of insurance than any other. The same rules of construction apply to it as to other contracts . . . ." Clay v. Phoenix Ins. Co., 97 Ga. 44, 53, 25 S.E. 417 (1895). Therefore, an unambiguous insurance

contract as any other contract must be construed to mean what it says. Fox v. Southern Glassine Co., 130 Ga. App. 124, 202 S.E.2d 563 (1973); Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 582, 168 S.E.2d 171 (1969). The rule applies equally to language which limits insurance coverage. Baker at 582; State Farm Mutual Auto Ins. Co. v. Sewell, 223 Ga. 31, 32, 153 S.E.2d 432 (1967).

In this instance, the language is clear and free from ambiguity, and according to the terms of the contract, by paying Lordmann for twenty-seven days of nursing care (three days having been paid earlier to another provider) at eighty percent coverage, less the amount paid to Lordmann by Blue Cross/Blue Shield, Equicor has met its obligations under the terms of the policy.

However, Plaintiff points to a provision for benefits payable for rehabilitation services, the relevant portion of which states:

This applies only to a person who: (a) is insured for health care benefits; and (b) while so insured has suffered a severe personal injury or sickness. If he or she becomes totally disabled due to such injury or sickness, the employer and the company may agree that:

1. The company pay benefits for reasonable and customary charges for rehabilitation services and supplies furnished to such person; and

2. Such benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan . . . .

As used above "a severe personal injury or sickness" means any of the following . . . neonatal high risk infants . . . . Any agreement to pay benefits in accord with

1. and 2. above will be based on an objective review of:

(a) the medical status;

(b) the current treatment plan;

(c) the projected treatment plan;

(d) the long term cost implication; and

(e) the effectiveness of care.

Booklet, p. 16.

Plaintiff asserts that because Victoria was a neonatal high risk infant who was totally disabled as a result of her physical condition, rehabilitative services[3] rendered by Lordmann are therefore covered, entitling Plaintiff to reimbursement for the remaining balance. Equicor has objected that in so claiming Lordmann ignores the language

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[3]The term "rehabilitation services" is not defined in the booklet-certificate, but Equicor has not objected to Lordmann's implicit assertion that the nursing services were rehabilitative in nature.

requiring an agreement between the employer and Equicor before rehabilitation services are covered, and that, because no evidence of such agreement has been offered, Lordmann has failed to present evidence on an element essential to its case, requiring entry of summary judgment in Equicor's favor. Plaintiff makes three responses: First, that the promise to pay rehabilitation benefits pursuant to an agreement entered between the employer and Equicor is illusory; second, that Equicor is equitably estopped from denying that such an agreement existed because of the representations made to Lordmann by Equicor's agent; and third, that Lordmann has in fact offered sufficient proof of an agreement between Equicor and Hi-Fi Buys.

However, all of these arguments fail for the same reason: There is no evidence anywhere in the record that Castagno made any representation about the availability of rehabilitation benefits, or even any reference to that provision

of the insurance contract. Without at least some reference by Equicor to that provision, Lordmann can show no genuine issue of material fact which would prevent entry of summary judgment.

C. Count IV

Count IV of Lordmann's amended complaint claims that Equicor fraudulently or negligently represented to Lordmann that all services rendered would be covered by the insurance plan, that Lordmann relied on that representation, and that under ERISA and the federal common law of equitable estoppel, Equicor should be estopped from denying coverage.

In Kane v. Aetna Life Ins., 893 F.2d 1283 (11th Cir. 1990), the court recognized that the federal common law of equitable estoppel may be applied to an ERISA-governed insurance plan when an oral interpretation of an ambiguous provision of the contract is made to an employee and the

employee relies on that interpretation. Several cases following Kane have either applied equitable estoppel or expressly left open the possibility that equitable estoppel could be applied in an instance when there is no ambiguity, but when the insurer makes a fraudulent representation. See, e.g., Alday v. Container Corp. of America, 906 F.2d 660 666 n.15 (11th Cir. 1990) ("We note that our holding does not insulate from liability a fiduciary who makes fraudulent promises in informal communications that deceive employees and contradict the terms of the SPD [summary plan description]. In such a case, there may be valid reasons for a court to look beyond the unambiguous language of the SPD in interpreting the plan.").

However, the federal common law of equitable estoppel cannot assist Plaintiff. There is no ambiguity in the terms of the plan that would allow an application of equitable

estoppel. Even assuming that a fraudulent misrepresentation about insurance coverage could serve as the basis for an application of equitable estoppel as suggested by the Alday dicta, Lordmann has failed to adduce any evidence of Equicor's intent to deceive, and consequently, there is no evidence of fraud. Without an interpretation of an ambiguity or a fraudulent misrepresentation, Lordmann is left with only an oral modification of an ERISA-governed insurance plan, which cannot be enforced. See Nachwalter v. Christie, 805 F.2d 956, 960 (11th Cir. 1986).

III. SUMMARY

Plaintiff's motion for leave to file a reply brief [22-1] is GRANTED, and for the foregoing reasons, Defendant's motion for summary judgment [17-1] is GRANTED.

SO ORDERED, this 30th day of September, 1993.

/s/
J. OWEN FORRESTER
UNITED STATES DISTRICT JUDGE

APPENDIX C
IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 93-9271

LORDMANN ENTERPRISES, INC.,

Plaintiff-Appellant,

versus

EQUICOR, INC.,

Defendant-Appellee.

On Appeal from the United States District Court for the
Northern District of Georgia

ON PETITION(S) FOR REHEARING AND

SUGGESTION(S) OF REHEARING EN BANC

Before: COX, Circuit Judge, MORGAN, Senior Circuit Judge, and COLLIER*, District Judge.

PER CURIAM:

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*Honorable Lacey Alexander Collier, U.S. District Judge for the Northern District of Florida, sitting by designation.

(x) The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT

/S/ Emmett R. Cox
UNITED STATES CIRCUIT JUDGE

FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
FEB 1, 1995
MIGUEL J. CORTEZ
CLERK

APPENDIX D

SECTION 514(a) OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1144(a)

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

94-1818

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No. 94-1178

In The

Supreme Court of the United States

October Term, 1994

EQUICOR, INC.,

Petitioner,

v.

LORDMANN ENTERPRISES, INC.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Does ERISA preempt all state law tort claims brought by health care providers against an ERISA plan administrator for torts committed in the course of performing its duties, where the health care provider is neither a participant nor beneficiary of an ERISA plan and thus is not entitled to sue under ERISA for the injuries it has suffered?

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No. 94-1178

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EQUICOR, INC.,

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On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF THE CASE

Respondent Lordmann Enterprises, Inc. (hereinafter "Lordmann") is a provider of pediatric home nursing services. Lordmann provided home nursing services to Victoria Mitchell, the infant daughter of Paula Rebecca Mitchell. Victoria was born with severe birth defects which required extensive hospitalization for the first four months of her life. When Victoria was finally discharged

from the hospital on July 30, 1990, she required home nursing care for 12 hours a day, seven days per week. Lordmann provided this care from July 30, 1990 until January 4, 1991. Without such care, Victoria Mitchell would in all likelihood have died as a result of her severe cardiovascular, gastrointestinal, and other birth defects.

Rebecca Mitchell and Victoria were eligible participants in an employee benefit plan sponsored by Hi Fi Buys, Inc., Mrs. Mitchell's employer. Under the terms of the plan, Mrs. Mitchell and Victoria were entitled to health care benefits provided by a group insurance policy issued by First Equicor Life Insurance Company. Petitioner Equicor, Inc. (hereinafter "Equicor") administered benefits and payments under the plan.

Victoria Mitchell's case was referred to Lordmann Enterprises, Inc. in July 1990, shortly before Victoria's discharge from Grady Hospital in Atlanta, Georgia. Before Lordmann began providing any services for Victoria, Lordmann's President, Susan Marot, contacted Equicor's case management office in Brea, California, to confirm the existence of insurance coverage.[1] The case marager, Geri Castagno, confirmed that the insurance policy covered 80% of the cost of Lordmann's services for 12 hours a day. Approximately one week later, the case

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[1] Equicor's Brief and the Eleventh Circuit's opinion both state that Lordmann Enterprises first contacted Equicor, Inc. *after* it began providing services to Victoria Mitchell. Equicor's Brief, at p. 5; *Lordmann Enterprises v. Equicor, Inc.*, 32 F.3d 1529, 1530 (11th Cir. 1994). However, the Affidavit of Susan Marot, which was cited by the Eleventh Circuit in its opinion, clearly states that she contacted Equicor *before* Lordmann began providing any services to Victoria Mitchell.

manager approved Lordmann's hourly rate of $50 per hour. Equicor did not disclose at that time the existence of any 30 day limit on coverage.

Based upon the representations of Equicor's case manager concerning the existence of coverage, Lordmann began providing home nursing services to Victoria Mitchell for 12 hours a day, seven days per week, commencing on July 30, 1990. Equicor's case manager continuously monitored the services being provided by Lordmann. On October 31, 1990, Lordmann's President updated Ms. Castagno concerning Victoria's condition and treatment and reconfirmed the existence of coverage under the policy for Lordmann's services. At that time, Ms. Castagno advised Lordmann's President that she could not find any provision in the plan limiting reimbursement for Lordmann's services to 80%. Ms. Castagno further advised Lordmann's President that case management had the authority to alter the plan and that she would arrange for coverage for Lordmann's services at the rate of 100 percent.

On December 11, 1990, Geri Castagno telephoned Lordmann's President and for the first time advised her that there was a question about coverage, but she would not elaborate. Lordmann's President asked Ms. Castagno whether Lordmann should discontinue its nursing services in light of the question about coverage. Ms. Castagno advised Lordmann's President not to discontinue nursing and again told her that case management had the authority to alter the plan and that Lordmann's services would be covered at the rate of 100 percent. Later that same day, Ms. Castagno telephoned Lordmann's President again and told her that Rebecca Mitchell had not

returned a case management form that Ms. Castagno had sent to her. Lordmann's President asked Ms. Castagno to fax the form to her so that she could have Mrs. Mitchell sign it, but Ms. Castagno refused to do that. Lordmann's President again asked whether Lordmann should discontinue its nursing services to Victoria Mitchell, and Ms. Castagno again told her not to discontinue treatment. Ms. Castagno at that time advised Lordmann's President that another insurance carrier was involved and that Lordmann would be paid 100 percent by one or the other of the carriers.

Lordmann provided home nursing care to Victoria Mitchell for 12 hours a day, seven days per week, until January 4, 1991, based upon the representations and assurances of Equicor's representatives. Throughout this period, Equicor monitored the treatment of Victoria Mitchell and was fully aware of the treatment being provided by Lordmann based upon its representations. However, Equicor subsequently refused to pay for the services it had induced Lordmann to provide. Relying upon language in the plan which limited coverage for home nursing care to 30 days in a calendar year, Equicor ultimately paid Lordmann for 80 percent of the cost of its services for 30 days during 1994 and for the four days during 1995, leaving a balance of almost $60,000.

Lordmann subsequently brought suit in the Superior Court of Fulton County, Georgia, asserting claims for fraud and negligent misrepresentation under Georgia law. These claims were asserted by Lordmann in its own capacity and not as an assignee of any rights of Victoria or Rebecca Mitchell. Equicor removed the case to the United States District Court for the Northern District of

Georgia, alleging as the basis for removal federal question jurisdiction and diversity jurisdiction. Lordmann subsequently amended its Complaint to assert two claims as assignee of Rebecca Mitchell's benefits under the plan.

The District Court subsequently granted summary judgment in favor of Equicor as to all four of Lordmann's claims. The District Court held that Lordmann's state law claims were preempted by ERISA, even though Lordmann was neither a participant nor a beneficiary under the plan. As to Lordmann's ERISA claims, the District Court held that the plan limited Equicor's liability for home nursing coverage to 80% of 30 days in a given calendar year and that Equicor was not estopped from contending otherwise. It held that this limitation was binding upon Lordmann, even though Lordmann had never even seen the plan and had relied entirely upon Equicor's representations concerning the amount of coverage.

The Eleventh Circuit Court of Appeals affirmed the District Court's grant of summary judgment as to Lordmann's fraud[2] and ERISA claims. However, the Eleventh

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[2] The Eleventh Circuit held that Lordmann's fraud claim was defective because there was insufficient evidence in the record to establish scienter, an essential element of a fraud claim under Georgia law. The Eleventh Circuit reached this conclusion even though Equicor's motion for summary judgment in the trial court had been based entirely upon the argument that the claim was preempted by ERISA. Since Equicor's argument in the District Court had not attacked the sufficiency of the evidence to support the claim but had addressed only the issue of whether the claim was preempted by federal law, Lordmann's response to the motion made no attempt to offer evidence as to

Circuit held that the Lordmann's claim for negligent misrepresentation under Georgia law was not preempted by ERISA. It is this ruling of the Eleventh Circuit which Equicor asks this Court to review.

SUMMARY OF THE ARGUMENT

This Court should not grant the writ of certiorari. The decision of the court below is consistent with the decisions of every circuit except the Sixth Circuit. The Sixth Circuit's decision in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991), which was a split decision with a vigorous dissent, is an anomaly which will remain unfollowed. Moreover, now that this Court

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each element of the claim. The District Court's grant of summary judgment as to the fraud claim was based entirely upon preemption grounds, as the Eleventh Circuit itself recognized. 32 F.3d at 1532, n. 2. The issue as to the sufficiency of the evidence to support the fraud claim was raised by Equicor for the first time in the Eleventh Circuit Court of Appeals. Even though it declined to consider the merits of the negligent misrepresentation claim since it had not been addressed by the trial court, and even though there was no reason for Lordmann to have introduced evidence to support each essential element of its fraud claim in the District Court, given the nature of the motion for summary judgment, the Eleventh Circuit agreed with Equicor's argument and held that there was insufficient evidence to support the fraud claim. *Id.* at p. 1532. The Eleventh Circuit reached this result even though there was ample circumstantial evidence from which a jury could have found intent to deceive Lordmann, including evidence that at the time Equicor was encouraging Lordmann to continue providing services on December 11, 1990, it had already decided not to pay for such services.

has clarified the meaning of the words "relate to" in Section 514(a) of ERISA, and given the growing number of federal circuit courts which have held that health care providers' state law claims are not preempted by ERISA, the Sixth Circuit will undoubtedly reconsider its decision. There is no need for any further guidance from this Court.

ARGUMENT IN OPPOSITION TO GRANTING OF WRIT OF CERTIORARI

A. THE APPARENT CONFLICT IN THE CIRCUITS CAN BE RESOLVED WITHOUT A RULING BY THIS COURT IN THIS CASE

Equicor asks this Court to review the Eleventh Circuit's holding that ERISA does not preempt a state law tort claim brought against an ERISA plan administrator by a third party health care provider who is neither a participant nor a beneficiary of an ERISA plan. Every circuit court which has addressed the issue, except the Sixth Circuit, has agreed that ERISA does not preempt such claims. *See The Meadows v. Employers Health Insurance*, 47 F.3d 1006 (9th Cir. 1995); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991); *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir, 1990). Those circuits, like the Eleventh Circuit in the case below, have recognized that preemption of claims such as those asserted by Lordmann below would defeat rather than promote the purposes of Congress in enacting ERISA. *Memorial Hospital System v. Northbrook Life Insurance Co.*,

904 F.2d 236, 245-247 (5th Cir. 1990). As this Court has previously noted, Congress enacted ERISA to protect the interests of employees and beneficiaries covered by benefit plans. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 113, 109 S. Ct. 948, 955, 103 L.Ed.2d 80 (1989). The Fifth, Ninth, Tenth and Eleventh Circuits have all recognized that entities which are neither participants nor beneficiaries of an ERISA plan are outside the "closely integrated regulatory system" Congress enacted to "promote the interests of employees and their beneficiaries in employee benefit plans". *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478, 112 L.Ed.2d 474 (1990). *See, e.g. Memorial Hospital*, 904 F.2d at 249 (5th Cir. 1990). These Courts have also recognized the commercial reality that third-party health care providers must be able to rely upon representations concerning coverage made by a plan administrator. *Memorial Hospital*, 904 F.2d at 247-248. If health care providers are unable to rely upon the representations concerning coverage made by the plan administrator, they will be forced either to deny care or to raise fees to protect themselves against the risk of non-coverage. *Id.* In either event, the employees whom Congress sought to protect would find medical treatment more difficult to obtain. *Memorial Hospital*, 904 F.2d at 246; *The Meadows v. Employee Health Insurance*, 47 F.3d at 1011.

The only Circuit Court which has held that state law claims brought by health care providers were preempted by ERISA has been the Sixth Circuit. *See Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d. 1272 (6th Cir. 1991). In that case, the Sixth Circuit, relying upon this Court's decisions in *Metropolitan Life Insurance Co. v. Mass.*, 471 U.S. 724, 730, 732-733, 105 S. Ct. 2380, 2385-86, 85 L.Ed.2d

728 (1985), and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983) held that the health care provider's state law claims were preempted by Section 1144(a) of ERISA because they "related to" an ERISA plan. In *Metropolitan Life* and *Shaw*, neither of which involved claims asserted by health care providers who were not participants or beneficiaries of a plan, this Court indicated that the words "relate to" in Section 1144(a) should be given a broad and expansive meaning because Congress intended to preempt the entire field of administration and enforcement of employee benefit plans. Using a literalist approach, the Sixth Circuit held that the health care provider's tort claims "related to" an ERISA plan because the conduct at issue had occurred as part of the plan administrator performing its duties under the plan and because it perceived the claim as, in essence, a claim for recovery of an ERISA plan benefit. *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991).[3] The Sixth Circuit held that the health care provider's state law claim was preempted by ERISA even though the health care provider would be left without any remedy whatsoever. The Sixth Circuit gave no consideration whatsoever to whether such a result would harm the very people Congress sought to protect when it enacted ERISA. The Sixth Circuit also gave no consideration to the fact that the health care provider was not a participant or beneficiary of the plan.

Even though there is an apparent conflict in the circuits concerning whether a third party health care

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[3] Lordmann's state law tort claim sought tort damages from Equicor, rather than benefits under the plan.

provider's state law claims against an ERISA plan administrator are preempted by ERISA, there is no reason for this Court to grant a writ of Certiorari in this case. The only circuit to hold that such claims are preempted by Section 1144(a) has been the Sixth Circuit, and its decision was based, in large part, on this Court's opinion in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983). In *Shaw*, this Court stated that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan", 463 U.S. at 96-97, although the Court did note that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 101, n. 21. The Sixth Circuit in *Cromwell* read this to mean that if a state law claim had any connection whatsoever with an employee benefit plan it would be preempted. However, this Court has recently revisted its interpretation of those words. In *New York State Conference of Blue Cross & Blue Shield Plans, et al., v. Travelers Insurance Company*, ___ U.S. ___, 113 S. Ct. 1671 (1995), this Court narrowed its earlier interpretation of the scope of ERISA's preemption of state law. The Court noted

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for "[r]eally, universally, relations stop nowhere." But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality. That said, we have to recognize that our prior attempt to

> construe the phrase "relate to" does not give us much help drawing the line here. . . . [H]ere an uncritical literalism is no more help than in trying to construe "relate to." For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.

___ U.S. at ___, 113 S. Ct. at 1671 (1995).

Although the *Blue Cross* case did not involve tort claims brought by a third party health care provider, its practical non-literalistic analysis of the term "relate to" should be helpful to the Sixth Circuit and lead it to reconsider its decision in *Cromwell*, especially in light of the unanimous decisions by the other circuits.[4] Since the conflict in the circuits can be resolved by reference to

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[4] Although the Sixth Circuit has not had another opportunity to review the issue of whether a third party health care provider's state law claims are preempted by ERISA, there is some indication that the Sixth Circuit is uncomfortable with the *Cromwell* decision and is already considering revisiting the issue when it comes before it again. In *Alexander v. Electronic Data Systems Corp.*, 13 F.2d 940 (6th Cir. 1994), the Court observed that the decision in Cromwell was split three ways, with the "majority" opinion being written by a Senior District Judge, and a separate opinion, concurring only in the result, being written by Judge Surheinrich. 13 F.2d at 946. The Sixth Circuit observed in *Alexander* that both the concurring opinion and the dissenting opinion in *Cromwell* had "held that the district court must 'make a separate inquiry at the outset to determine whether the plaintiff is a "participant" . . . within the meaning of ERISA, before it turns to the issue of preemption.' " *Id.*

existing precedent, there is no need for the Court to consider this case to resolve the conflict.

B. THE DECISION OF THE COURT BELOW WAS CORRECT.

If this Court does grant certiorari, it should summarily affirm the Eleventh Circuit's decision, as that decision is the proper result and is consistent with this Court's precedent. ERISA does not preempt a healthcare provider's state-law claims for several reasons, including the following:

1. A state-law claim may, literally speaking, "relate to" an ERISA plan and yet not be preempted by ERISA. *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Co.*, ___ U.S. ___ (1995). For example, according to this Court, (i) ERISA does not bar an employee's creditor from garnishing (under state law) an employee's benefits under an ERISA-covered welfare benefit plan, even if the garnishment suit subjects the plan to substantial administrative costs, and (ii) neither does ERISA bar suits against an ERISA plan (under state law) for run-of-the-mill claims such as unpaid rent or other debts or even torts committed by the plan's agents. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S. Ct. 2182, 100 L.Ed.2d 836 (1988). To determine whether a state-law claim "relates to" an ERISA-covered plan in a way requiring preemption, a court must consider ERISA's *scope* and *purposes*.

2. ERISA deals primarily with the rights and obligations of the employer, the plan's insurer (and the plan's administrator and any other fiduciaries), and the plan's

beneficiaries *as among themselves*. ERISA does not determine the obligations of these parties to *outsiders* such as healthcare providers. Put another way, ERISA strikes a bargain: it takes away certain rights that the employer, insurer, and beneficiaries would have against each other under state law and in lieu of these rights it provides other rights. Outsiders such as healthcare providers are not parties to this bargain. ERISA neither takes away their rights under state law nor gives them any new rights. ERISA does not address their rights at all. In short, healthcare providers are *beyond ERISA's scope*.[5]

3. Congress enacted ERISA to protect the interests of the plan's beneficiaries. If ERISA barred healthcare providers from pursuing their state-law remedies for inaccurate information about coverage, this purpose would be defeated because *beneficiaries of employer-sponsored plans would find medical care more difficult to obtain*. If providers could not rely on insurers' statements about patients' coverage under employer-sponsored health insurance policies, then providers would need to insist that such patients pay in advance or provide some other form of protection, such as evidence of ability to pay or a guarantee of payment from some third party. Alternatively, to offset the increased risk of nonpayment, providers would need to raise their fees.

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[5] The Sixth Circuit has recently acknowledged that, in determining whether a claim is preempted, a primary factor to consider is whether the claim will affect relations among the principal ERISA entities (employer, plan fiduciaries, and beneficiaries). *Van Camp v. AT&T Information Systems*, 963 F.2d 119, 123 (6th Cir. 1992).

4. Preempting healthcare providers' state-law remedies would ignore *commercial realities*. Healthcare providers are not in the business of verifying insurance coverage. Their business is caring for and treating patients. By contrast, insurers are in the business of verifying coverage, and they have in their files the applications, policies, coverage limits, claims histories, and other information needed to do it. Moreover, insurers routinely provide such verification and are aware that providers rely on it. In light of these commercial realities, it is appropriate that insurers be held accountable if their verifications are inaccurate.

5. Finally, federal preemption would override the *states' traditional authority* to resolve business disputes and allocate business risks between commercial entities. Given that such matters have traditionally been matters of state law, the courts should require clear evidence that Congress intended for such state laws to be overridden.

An insurer may argue that permitting healthcare providers to assert state-law claims for negligent misrepresentation, fraud, etc. will subject plan fiduciaries to inconsistent or conflicting regulation under the laws of different states, thereby thwarting ERISA's purpose of establishing a uniform body of law. However, ERISA seeks to establish a uniform body of law only for the purpose of regulating the principal ERISA entities (employer, insurer and other fiduciaries, and beneficiaries) in their dealings with each other. For example, ERISA seeks to impose uniform rules for determining eligibility, reviewing and paying claims for benefits, keeping records, disclosing information to participants, and filing reports with governmental agencies. State laws

regulating *these* matters would conflict with ERISA. State laws concerning misrepresentations to service providers, however, do *not* conflict with ERISA, because such state laws regulate dealings with outsiders, which are beyond ERISA's scope.

Moreover, uniformity is not ERISA's only goal. Congress enacted ERISA also to protect the interests of the plan's beneficiaries, and, as explained above, this purpose would be defeated if healthcare providers' claims were preempted.

An insurer may also argue that if state-law claims for misrepresentation are not preempted, insurers for ERISA-covered plans will stop providing coverage information to healthcare providers. However, insurers routinely provide coverage information to healthcare providers in cases of *non*-ERISA-covered insurance policies, despite the risk of liability under state law if the information is false. Insurers do this for rational business reasons. If an insurer refused to provide such information, providers would insist that patients pay in advance or provide evidence of ability to pay, a third-party guarantee, etc. or would charge higher rates to patients covered under that insurer's policies (to cover the increased risk of nonpayment) – which, in turn, would induce the insurer's policyholders to switch to another insurer. These business reasons will induce insurers to continue to provide coverage verification in the case of ERISA-covered insurance policies, as well.

It may also be argued that healthcare providers should simply obtain an assignment of the patient's rights under the plan and review the plan document for

themselves. However, ERISA-covered insurance plans do not always permit such assignments.[6] Even if all ERISA plans did permit such assignments – and even if it were practicable for healthcare providers to review each patient's insurance policy – healthcare providers could not determine coverage merely by reviewing the plan document. Coverage depends on a number of factors outside the plan document, such as the patient's status as an eligible employee or dependent, whether the patient's condition is a pre-existing condition, whether previous claims have exceeded the policy's limits, and so on. A healthcare provider cannot determine such matters without inordinate expense, which would have to be passed on to patients. An insurer can, and routinely does, as part of its business, and is in a position to be much more efficient at doing so.

Non-preemption of a healthcare provider's claims is consistent with this Court's previous decisions. *See New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Co.*, ___ U.S. ___ (1995) (rejecting a literalistic interpretation of "relate to"); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988) (ERISA does not bar an employee's creditor from garnishing an employee's benefits under an ERISA-covered welfare benefit plan, even if the garnishment suit subjects the plan to substantial administrative costs; neither does ERISA bar suits against an ERISA plan for run-of-the-mill claims such as unpaid rent or other debts or even torts

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[6] In such cases, under Equicor's analysis, a healthcare provider would have no remedy whatsoever except, perhaps, against the plan participant.

committed by the plan's agents). This Court has also indicated that the converse holds true – i.e., that ERISA does not bar a plan fiduciary from suing a third-party service provider under state law. *Mertens v. Hewitt Associates*, ___ U.S. ___, 113 S. Ct. 2063, 2067-2068, 124 L.Ed.2d 161 (1993) (Court suggested that if given the chance, it would hold that nonfiduciaries – e.g., third-party service providers – cannot be sued under ERISA for any sort of relief, whether in the form of money damages or otherwise, such suits being left to state law).

Cases where this Court has held that ERISA does preempt a claim [such as *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)] have all involved claims between the principal ERISA entities (employer, plan fiduciaries, and plan beneficiaries). This Court has never held that ERISA preempts state law claims asserted by entities who are neither participants, beneficiaries, nor fiduciaries under an ERISA plan.

CONCLUSION

For all of the foregoing reasons, Lordmann respectfully requests that the Court deny the Petition for a Writ of Certiorari. In the alternative, Lordmann respectfully requests that the Court summarily affirm the decision of the court below.

Respectfully submitted, this 1st day of June, 1995.

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No. 94-1818

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In the Supreme Court of the United States

OCTOBER TERM, 1995

EQUICOR, INC., PETITIONER

v.

LORDMANN ENTERPRISES, INC.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, preempts a state law tort claim brought by a health care provider against an ERISA benefits administrator for negligently misrepresenting to the provider that the provider would be paid in full for all services that it rendered to a plan participant.

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In the Supreme Court of the United States

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. Paula Mitchell was a participant in an employee welfare benefit plan sponsored by her employer, Hi-Fi Buys, Inc. Pet. App. A2. Under the terms of the plan, Mitchell and her infant daughter, Victoria, were eligible for health care benefits provided by a group insurance policy issued by First Equicor Life Insurance Co. (First Equicor) and administered by petitioner Equicor, Inc. *Ibid*; *id.* at B2. The policy, which

went into effect on June 1, 1990, provided for only 30 days of home nursing care per calendar year, but stated that Hi-Fi and petitioner could agree to cover further rehabilitation services if an insured became disabled because of "severe personal injury," a category that expressly included high-risk newborn infants. *Id.* at A2-A3.

Victoria was born in February 1990 with severe birth defects that required her to be hospitalized for almost the first five months of her life. Pet. App. A3, B2. After she was released from the hospital, Victoria required 12 hours of home nursing care each day. *Ibid.* Mitchell hired a nurse employed by respondent Lordmann Enterprises, Inc., to provide that care, and assigned to Lordmann her rights to benefits under the plan. *Id.* at A3, B2-B3. The content of the communications that followed between respondent and petitioner is disputed.

Respondent claims that, in July 1990, before providing its services, Susan Marot, its chief executive officer, contacted petitioner and was informed by Geri Castagno (of petitioner's Medical Case Management Department) that the plan would pay 80% of the cost of the proposed nursing care. Pet. App. A3-A4, B3. In October, when Marot called to update petitioner on Victoria's condition, Castagno represented that she had authority to increase the benefits payable and that she would arrange to have 100% of the nursing charges paid. *Id.* at A4, B3. Approximately six weeks later, Castagno informed Marot that there was a problem with Victoria's coverage. Castagno stated, however, that there was no need to discontinue nursing services, and assured Marot that so long as respondent billed Blue Cross/Blue Shield (the insurer

at the time of Victoria's birth) first, respondent would be paid in full for its services. *Id.* at A5, B3-B4.

For its part, petitioner agrees that Marot asked Castagno about coverage for Victoria's nursing care, but claims that Castagno stated only that nursing services "would be covered under group policy number 72610, or not covered, subject to the terms and conditions of the contract of insurance." Pet. App. B4-B5, A6.

Respondent completed its care for Victoria in January 1991. Pet. App. A6. In December 1991, First Equicor paid petitioner $9,952, which was 80% of respondent's bill for 30 days of care in 1990 and four days of care provided in January 1991, less the amount owed by Blue Cross/Blue Shield for the same care. Respondent collected $3,425 from Blue Cross/Blue Shield, leaving a balance of $59,432. *Id.* at A6, B5.

2. Respondent sued petitioner in state court in Georgia, asserting state law claims for fraudulent and negligent misrepresentation. Pet. App. A6-A7, B5. Petitioner removed the case to federal court, asserting federal question and diversity jurisdiction. *Id.* at A7. Respondent then amended its complaint to add two federal claims, in its capacity as Mitchell's assignee: a claim for plan benefits under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*; and an ERISA claim based upon federal common law equitable estoppel. Pet. App. A7, B5-B6.

In response to petitioner's motion for summary judgment, the district court held that respondent's state law fraud and negligent misrepresentation claims were preempted by Section 514(a) of ERISA, 29 U.S.C. 1144(a). Pet. App. B6-B9. Although the court acknowledged (*id.* at B8) that the claims "d[id] not

directly implicate the employee benefit plan," it reasoned (*id.* at B9) that allowing Lordmann, which was an assignee of a plan beneficiary, to make state law claims against the plan would permit it "to do that which a beneficiary cannot do under state law," and thus frustrate the purposes of the ERISA preemption provision.

The court also held that respondent could not prevail on its ERISA-based claims. It rejected respondent's claim for benefits under the plan itself, because the unambiguous terms of the written plan provided only for 80% coverage for 30 days per calendar year. Pet. App. B14, B18. The court recognized that the plan permitted Hi-Fi and petitioner, by agreement, to provide additional coverage for rehabilitation, but found that respondent had failed to present any evidence of such an agreement. *Id.* at B16-B18. The court then rejected respondent's federal common law equitable estoppel claim, because, it concluded, the terms of the written plan were clear and respondent presented no evidence that petitioner had spoken with an intent to deceive. *Id.* at B18-B20.

3. The court of appeals affirmed the dismissal of respondent's two ERISA-based claims for the reasons stated by the district court, Pet. App. A18-A22, and it also affirmed the dismissal of respondent's state law fraud claim on the ground that respondent failed to allege specific facts that would support an inference of scienter, *id.* at A10-A11. But the court reversed the judgment entered against respondent on its claim for negligent misrepresentation, concluding that the claim might be viable under Georgia law, *id.* at A11-A12, and agreeing with the Fifth and Tenth Circuits that state law claims brought by health care providers against plan insurers "too tenuously affect the

ERISA plans to be preempted by the Act," *id.* at A13-A14 (citing *Hospice of Metro Denver, Inc.* v. *Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991), and *Memorial Hospital Sys.* v. *Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990)). In the court's view, preemption in this situation would defeat, rather than promote, the statutory goal of protecting plan participants, since health care providers might hesitate to provide services, or might raise their fees, if they could not rely on representations by insurers or plan administrators regarding coverage. Pet. App. A15-A16. Moreover, the court found regulation of the relationship between plan fiduciaries and health care providers (who "were not parties to the ERISA 'bargain'" and were not afforded "federal causes of action under ERISA") to be beyond the scope of the Act. *Id.* at A16-A17.

ARGUMENT

The decision of the court of appeals is correct, and it is in accord with decisions of the Fifth, Ninth and Tenth Circuits. Although the Sixth Circuit reached a contrary result in *Cromwell* v. *Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (1991), cert. dismissed, 113 S. Ct. 2 (1992), the Sixth Circuit's ruling in that case rested on a view of ERISA preemption that this Court since disapproved in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 115 S. Ct. 1671 (1995). Because the Sixth Circuit may, accordingly, revisit the issue and reach a result consistent with that of the other courts of appeals, further review at this juncture would be premature.

1. ERISA supersedes all state laws insofar as they "relate to" an ERISA plan. 29 U.S.C. 1144(a). The Court held in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S.

41. 47 (1987), that the phrase "relate to" should be accorded a "broad common-sense meaning," and explained in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to uch a plan." Under that construction, a state law may "relate to" an employee benefit plan, and be preempted, even if the law is not specifically or directly designed to affect such a plan. *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 139 (1990).

This Court has made clear, however, that pre-emption is not unlimited, and that some state actions may affect employee benefit plans "in too tenuous, remote, or peripheral a manner" to warrant a finding that they "relate to" a plan. *Shaw*, 463 U.S. at 100 n.21. That is so, the Court has explained, with respect to "many laws of general applicability." *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 n.1 (1992). Thus, the Court held in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), that ERISA does not pre-empt garnishment of plan benefits under state law, and noted in that regard that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan—are relatively commonplace," *id.* at 833.

Most recently, in *Travelers*, this Court rejected "uncritical literalism" in gauging the "measure of pre-emption" under ERISA, recognizing that, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." 115 S. Ct. at 1677; see also *ibid.* ("For the same

reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections."). Accordingly, the Court found it necessary to "go beyond the unhelpful text and the frustrating difficulty of defining [the] key term [of the ERISA preemption provision], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Ibid.* It explained that ERISA preempts state laws "that mandate[] employee benefit structures or their administration," or that provide "alternat[ive] enforcement mechanisms," *id.* at 1678, because such laws are inconsistent with ERISA's goal of providing a "nationally uniform administration of employee benefit plans," *id.* at 1677-1678. But, invoking the "presumption that Congress does not intend to supplant state law," *id.* at 1676, the Court found that the New York hospital surcharge law at issue in *Travelers* did not "relate to" ERISA plans, despite the law's admitted purpose to make Blue Cross/Blue Shield coverage more economically attractive by exempting from the surcharge patients covered by Blue Cross/Blue Shield policies. The "indirect economic influence" of the surcharge law, like other laws that indirectly affect, but do not dictate, ERISA plans' market choices, was not sufficient to trigger preemption. *Id.* at 1679-1680.

2. The court of appeals' holding in this case is consistent with this Court's teachings. The cause of action for negligent misrepresentation under Georgia law does not refer to, and is not dependent on, the existence of an ERISA plan. See *Ingersoll-Rand*, 498 U.S. at 139 (distinguishing the state wrongful discharge law held preempted in that case from "a generally applicable statute that makes no reference

to, or indeed functions irrespective of, the existence of an ERISA plan"). Respondent's action also has no direct economic or administrative impact on the ERISA plan sponsored by Paula Mitchell's employer. It is not an action against the plan itself, but against the plan administrator, and it is not based on the participant's plan coverage, but on an assurance made by the administrator to a third-party provider. Any "one-time recovery * * * would not affect the on-going administration or obligations" of the plan, or expand the rights of the participant or her beneficiary to receive benefits under the terms of the plan. *Memorial Hospital*, 904 F.2d at 247; see also *id.* at 246.[1] In fact, Mitchell (the plan participant) is individually and primarily liable to pay for the services rendered by respondent, with the only question being whether the risk of non-payment should remain with the provider or be shifted to the plan administrator that allegedly misrepresented coverage. See *ibid.* "Enforcing the allocation of risks between com-

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[1] If respondent prevails in this action, petitioner will have to pay a judgment that presumably will be measured by the cost of unpaid services that respondent provided. But the employer's ERISA plan itself will not be modified, and the judgment will not affect its benefit structure generally or require changes in its administration. Cf. *Travelers*, 115 S. Ct. at 1678 (ERISA preempts "state laws that mandate[] employee benefit structures or their administration"). It is possible that the cost incurred by petitioner in paying the judgment will ultimately be borne in whole or in part by the ERISA plan, either pursuant to its contract with petitioner as administrator or in the form of higher rates for administrative services in the future. That consequence, however, would be the type of indirect and purely economic impact on plans that *Travelers* held insufficient to trigger preemption.

mercial entities that conduct business in a state is a classically important state interest" (*ibid.*) that "ERISA pre-emption analysis 'must * * * respect.'" *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 19 (1987).

Further, unlike respondent's claim for benefits directly under the ERISA plan and respondent's assertion of equitable estoppel, which derive from respondent's status as Mitchell's assignee, respondent's allegation of negligent misrepresentation is based on its independent status as a third-party health care provider. Health care providers are not ERISA principals; and although, as here, they may have certain derivative rights under ERISA if they have received a valid assignment from a participant or beneficiary, they do not have independent standing to seek redress under ERISA. See, *e.g.*, *Hermann Hospital* v. *MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1290 (5th Cir. 1988). As the court below recognized, "[w]hen employers and employees gave up state law causes of action because of ERISA, they received federal causes of action under ERISA in exchange[,] [but] ERISA does not provide a cause of action for aggrieved health care providers that treat ERISA participants." Pet. App. A17. Because regulation of the provider/administrator relationship falls outside the scope of the Act, misrepresentation claims raised by health care providers do not "raise[] any issue concerning the matters that Congress intended to be regulated exclusively by ERISA." *Memorial Hospital*, 904 F.2d at 247. Rather, they are representative of the "run-of-the-mill state-law claims" that are beyond the sweep of ERISA pre-emption. *Mackey*, 486 U.S. at 833; cf. *Rebaldo* v. *Cuomo*, 749 F.2d 133, 138 (2d Cir. 1984) (ERISA

preemption "does not require the creation of a fully insulated legal world that excludes those plans from regulation of any purely local transaction"), cert. denied, 472 U.S. 1008 (1985).

Finally, it is unclear "how insulating plan fiduciaries from the consequences of their commercial dealings with third-party providers would further any of ERISA's goals." *Memorial Hospital*, 904 F.2d at 247. Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989) (citation omitted); see also 29 U.S.C. 1001(b). To that end, Congress intended, through the Act, to give employers the advantages of a uniform set of regulations governing plan fiduciary responsibilities and procedures for processing claims and paying benefits. *Travelers*, 115 S. Ct. at 1677-1678; *Fort Halifax*, 482 U.S. at 9-11. As the court below determined, however, preempting respondent's state law claim for misrepresentation would directly undercut the interests of participants and beneficiaries, because "commercial realities" require that "providers be able to rely on the insurers' representations as to coverage." Pet. App. A15.[2] If health care providers have no recourse

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[2] See *Memorial Hospital*, 904 F.2d at 246:

> The scenario * * * is reenacted each day across the country. A patient in need of medical care requests admission to a hospital (or seeks treatment from a doctor). The costs of medical care are high and many providers have only limited budget allocations for indigent care and for losses from patient nonpayment. Naturally, the provider wants to know if payment reasonably can be expected. Thus, one of the first steps in accepting a

in circumstances in which they have been misled by erroneous assurances about the extent of coverage, they "must either deny care or raise fees to protect themselves against the risk of noncoverage," Pet. App. A16, thereby harming the interests of participants and of the plans themselves in ensuring that medical services are readily available to covered employees and their dependents.

3. Petitioner argues (Pet. 16, 22-23) that because a plan administrator acts within the scope of its official duties when it provides information regarding the existence and extent of coverage under a benefit plan, the propriety of its conduct should be determined by a uniform body of federal law under ERISA, regardless of whether the plaintiff is a plan participant or, as here, a third-party health care provider. That a function is performed by a person in its capacity as a plan administrator does not mean, however, that its actions are insulated from state law causes of action.

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patient for treatment is to determine a financial source for the cost of care to be provided.

If a provider believes that a patient may be covered under a health care plan, it is customary practice to communicate with the plan agents to verify eligibility and coverage. If the provider confirms that a patient has health insurance that covers a substantial part of the expected costs of the health care, it will normally agree to admit the patient without further ado. Memorial contends that when an insurance company or its agent, including one acting as an ERISA plan fiduciary, verifies coverage to a third-party provider, the insurer should recognize the commercial implications to the provider of its assurances. Under Memorial's theory, the insurance company is agreeing to pay expenses within the represented terms of the policy or to accept the consequences for a false representation of coverage that the provider reasonably relied upon.

Indeed, as this Court has recognized, an ERISA plan may itself sue and be sued under state tort law. *Mackey*, 486 U.S. at 833.[3] Moreover, contrary to petitioner's assertion (Pet. 16), the identity of the party plaintiff is relevant to the determination whether its claim against an ERISA principal is preempted. ERISA preempts state law claims by beneficiaries against plan fiduciaries because, by defining the fiduciaries' duties towards plan beneficiaries and providing a mechanism for enforcement of those duties, the Act establishes a comprehensive scheme for regulation of the fiduciary/beneficiary relationship. In contrast, "[t]he Act imposes no fiduciary responsibilities in favor of third-party health care providers," *Memorial Hospital*, 904 F.2d at 247, and affords such providers no statutory cause of action for redress of injuries inflicted by plan fiduciaries.

Petitioner contends (Pet. 19-22) that the absence of an ERISA remedy for misleading statements made by plan administrators to health care providers is not relevant to the preemption analysis. Neither *Cater-*

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[3] Significantly, *Mackey* cited *Abofreka* v. *Alston Tobacco Co.*, 341 S.E.2d 622 (S.C. 1986), as an example of a type of tort claim commonly brought against plans or their fiduciaries that is not preempted by ERISA. 486 U.S. at 833 n.8. *Abofreka* involved a state libel claim by a doctor against plan fiduciaries who, based on their belief that the doctor had submitted fraudulent claims for benefits, posted notices to their covered employees not to use the doctor's services. 341 S.E.2d at 624. As the Fifth Circuit noted in *Memorial Hospital*, if ERISA does not preempt the *Abofreka* claim, despite its undeniable connection to the administrative activities of plan fiduciaries in processing the doctor's claims for benefits, a state law claim by a health care provider against a plan administrator for negligent misrepresentation "creates no greater preemptive concerns." 904 F.2d at 248-249.

pillar, Inc. v. *Williams*, 482 U.S. 386 (1987), nor *Avco Corp.* v. *Aero Lodge No. 735, Int'l Ass'n of Machinists*, 390 U.S. 557 (1968), supports that broad argument. Although both cases held that a state law cause of action may be preempted by Section 301 of the Labor Management Relations Act, 29 U.S.C. 185, even where federal law does not provide a parallel remedy, *Caterpillar*, 482 U.S. at 391 n.4; *Avco*, 390 U.S. at 561, neither case held that the existence *vel non* of a federal remedy is irrelevant to an analysis of the scope of federal preemption. To the extent that the presence or absence of a remedy under ERISA bears on Congress's intent regarding the scope of the Act, it is obviously a factor relevant to an assessment of the Act's preemptive range. See *Travelers*, 115 S. Ct. at 1677-1678.

Finally, petitioner argues (Pet. 22) that a health care provider's interests can be adequately protected, without resort to state tort law, through an assignment of the beneficiary's rights under the plan. Limiting a provider to the remedies available to the plan beneficiary, however, fails to take into account relevant differences in their respective positions. As a general rule, a beneficiary is held to the written terms of a plan and cannot enforce alleged oral representations or modifications that conflict with those written terms.[4] That is so because the written

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[4] In general, oral or informal written communication has been deemed ineffective to amend the terms of a written plan. See *Coleman* v. *Nationwide Life Ins. Co.*, 969 F.2d 54, 58-59 (4th Cir. 1992), cert. denied, 113 S. Ct. 1051 (1993); *Cefalu* v. *B.F. Goodrich Co.*, 871 F.2d 1290, 1295-1297 (5th Cir. 1989); *Moore* v. *Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988); *Straub* v. *Western Union Telegraph Co.*, 851 F.2d 1262,

plan document requirement of Section 402(a)(1) of ERISA, 29 U.S.C. 1102(a)(1), and the Act's reporting and disclosure scheme more generally, are designed to "enabl[e] beneficiaries to learn their rights and obligations at any time," *Curtiss-Wright Corp.* v. *Schoonejongen*, 115 S. Ct. 1223, 1230 (1995). See 29 U.S.C. 1024(b) (1988 & Supp. V 1993) (requiring the plan administrator to furnish participants and beneficiaries with a copy of the summary plan description and to make plan documents available for inspection by participants and beneficiaries). In light of this statutory scheme, it is one thing to hold a beneficiary responsible for knowing the terms of the plan under which she claims coverage, and quite another to presume that a third-party provider, who deals with numerous unrelated plans without having ready access to the governing plan documents, stands on equal footing with the administrator of a plan regarding matters of eligibility and coverage under that plan.

4. The decision of the court of appeals in this case is consistent with decisions of the Fifth, Ninth and Tenth Circuits holding that similar claims by health care providers are not preempted by ERISA. See *Memorial Hospital*, 904 F.2d at 245-249; *Hospice of Metro Denver*, 944 F.2d at 755; *The Meadows* v. *Employers Health Ins.*, 47 F.3d 1006, 1008, 1011 (9th Cir. 1995).[5]

1265 (10th Cir. 1988); *Nachwalter* v. *Christie*, 805 F.2d 956, 960 (11th Cir. 1986).

[5] Notably, the Fifth and Ninth Circuits have distinguished state law suits by a provider "as an *independent* entity claiming *damages*" from state law suits by a provider "as an *assignee* of a beneficiary's rights to *benefits*," and have found the lat-

The Sixth Circuit's decision in *Cromwell* v. *Equicor-Equitable HCA Corp.*, *supra*, thus stands alone in holding that a health care provider's state law claim against a plan administrator for negligently misrepresenting the extent of coverage is preempted by ERISA.[6] In *Cromwell*, a health care provider brought suit in state court based on the administrator's false assurance of coverage and subsequent refusal to pay. The provider alleged promissory estoppel, negligence, and, as an assignee of insurance benefits, derivative claims for breach of contract and breach of good faith. 944 F.2d at 1276-1277. After the case was removed to federal court, the district court dismissed the provider's state law claims as preempted by ERISA, and it granted the administrator's motion for summary judgment on the breach of contract and breach of good faith claims, which the court treated as claims for benefits under the Act. *Id.* at 1275. The court of appeals affirmed. Stressing the broad sweep of ERISA preemption, the court reasoned

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ter preempted by ERISA. *The Meadows*, 47 F.3d at 1008 (distinguishing *Misic* v. *Building Service Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986)); *Memorial Hospital*, 904 F.2d at 245 n.12, 249 n.20, 250 (distinguishing *Hermann Hopsital* v. *MEBA Medical & Benefits Plan*, *supra*).

[6] Although the Fourth Circuit stated, in *Baker Hospital* v. *Aetna Life Ins. & Casualty Co.*, No. 91-2004, 1991 WL 179113, at *1 (July 29, 1991) (per curiam), that ERISA precluded a provider's state law promissory estoppel claim, the opinion was unpublished (and therefore did not establish circuit precedent), and the provider in that case conceded that its claims were preempted by ERISA. Similarly, in *Baker Hospital* v. *Isaac*, 391 S.E.2d 549, 550-551 (S.C. 1990), the parties stipulated that the provider's state law tort claims were preempted by ERISA. Both of those decisions predated *Travelers*.

that the state law claims were "at the very heart of issues within the scope of ERISA's exclusive regulation and, if allowed, would affect the relationship between plan principals by extending coverage beyond the terms of the plan." *Id.* at 1275-1276.

The decision in *Cromwell*, however, was split three ways, with only Senior District Judge Feikens subscribing to the above reasoning. Judge Suhrheinrich, concurring only in the result, focused on "the effect state law has on the plan." 944 F.2d at 1279. In his view, a judgment in this type of case, while not based in contract, "will nonetheless have to be paid by the plan"; "will require actuarial adjustments, since such a judgment will not have been a factor in the plan's projections"; and will subject the plan "to the laws of the individual states concerning the types of damages recoverable in tort, including consequential and punitive damages." *Ibid.* Judge Suhrheinrich concluded that those effects trigger preemption, because they result in "fewer funds available to pay the claims of beneficiaries" and "increase administrative costs." *Ibid.*

Judge Jones, dissenting, faulted the "majority" for its "overzealous" and "unreflective approach to ERISA preemption," 944 F.2d at 1279, an approach that "perhaps inadvertently * * * has enabled plan administrators, either intentionally or not, to give misinformation of coverage and avoid any inquiry into the validity of a health care provider's claims against them," *id.* at 1286.

The rationale of Judge Suhrheinrich's concurrence, which apparently was pivotal to the outcome of the case, see *Marks* v. *United States*, 430 U.S. 188, 193 (1977), is directly called into question by this Court's

later decision in *Travelers*. The "negative effects" on plans of holding plan administrators liable for torts committed against outside parties, like the effects of the surcharges in *Travelers*, are indirect and wholly economic, and "do[] not bind plan administrators to any particular choice." *Travelers*, 115 S. Ct. at 1679. It was precisely the existence, and indeed prevalence, of "common state action[s]" having such economic impacts that led this Court to question, and ultimately reject, the notion that ERISA displaces "all state laws affecting costs and charges." *Ibid.* As a result of *Travelers*' subsequent clarification of the standards for ERISA preemption, the Sixth Circuit may well reconsider its splintered ruling in *Cromwell* concerning the viability of a health care provider's independent state law claims against a plan administrator. Accordingly, we do not believe that review of that issue by this Court is warranted at the present time.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

EQUICOR, INC.,

Petitioner,

v.

LORDMANN ENTERPRISES, INC.,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

SUPPLEMENTAL BRIEF OF PETITIONER

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SUPPLEMENTAL BRIEF OF PETITIONER

Petitioner Equicor, Inc. submits this supplemental brief in response to the brief for the United States as amicus curiae. The government argues that this Court should not grant the petition for writ of certiorari, but ignores the pressing need for certainty on an issue critical to the efficient delivery of health care. The government's erroneous position on the merits also is affected by its failure to appreciate fully the impact of the Eleventh Circuit's decision on employee benefit plan administration. The government's unduly expansive reading of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), exacerbates the misimpression its brief advances.

1. The question presented in this case is whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001 *et seq.*, preempts a state law claim brought by a health care provider against an employee benefit plan administrator for alleged tortious conduct in the administration of the plan. Specifically, can a health care provider sue an employee benefit plan administrator under state law because the provider relied upon alleged characterizations by the administrator regarding coverage under the plan? The interactions that give rise to such claims are commonplace. Health care providers phone medical plan administrators tens of thousands of times each day inquiring about covered expenses under a patient's employee benefit plan. The question here is whether the plan administrator's legal obligations in responding to these myriad inquiries are to be governed by a uniform body of federal law, or to be determined according to the diverse requirements of the several states.

It would be difficult to understate the importance of this question for plan administrators, plan sponsors, and employee benefit plan beneficiaries. The accumulation of state law liability on top of a plan administrator's ERISA obligations necessarily will alter plan administration and increase costs, not only because of differences in substantive requirements but also because state law may provide for punitive damages or other recovery not available under ERISA. These administrative changes and additional costs will be felt by plan sponsors, who pay for plan administration, and by plan beneficiaries in the form of less efficient administration, higher deductibles and copayments, and fewer covered services.

The great prevalence of state law claims like that in this case demonstrates not only the importance of the issue, but the necessity for this Court to announce a single rule. In its brief, the government overlooks the urgent need for certainty on an issue that arises with such extraordinary frequency. Regardless of what the Court ultimately decides, benefit plan administrators must understand fully their obligations and potential liability when communicating with health care providers. This Court can provide such service to consumers of the law.

The split of authority that the Eleventh Circuit's decision implicates, and the uncertainty it has created, is considerably more extensive than the government acknowledges. In addition to the Sixth Circuit's decision in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1275-76 (6th Cir. 1991), *cert. dismissed*, 113 S. Ct. 2

(1992),[1] the Fourth and Fifth Circuits and the Supreme Court of South Carolina also have held, contrary to the Eleventh Circuit, that ERISA preempts state law claims by health care providers against plan administrators. *See Baker Hosp. v. Aetna Life Ins. Casualty Co.*, 1991 WL 179113 (4th Cir. 1991); *Hermann Hosp. v. MEBA Med. & Benefits Plan (Hermann I)*, 845 F.2d 1286, 1290 (5th Cir. 1988), *adhered to on appeal after remand*, 959 F.2d 569, 576-79 (*Hermann II*) (5th Cir. 1992); *Baker Hosp. v. Isaac*, 391 S.E.2d 549, 550-51 (S.C. 1990).

The government's attempt to diminish the effect of these decisions is wholly unconvincing. For example, the government notes that the plaintiffs in the Fourth Circuit and South Carolina cases conceded ERISA preemption. U.S. Brief at 15 n.6. This distinction ignores that in both cases the court explained that such concessions were mandated by the law. The Fourth Circuit held that plaintiff's common law claims were "[i]ncluded within [ERISA's] statutory preemption." *Baker Hosp. v. Aetna*, 1991 WL 179113 *1. The South Carolina Supreme Court followed its discussion of the ERISA preemption issue with a declaration that it "ha[d] determined that the instant common law claims are pre-empted." *Baker Hosp. v. Isaac*, 291 S.E.2d

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[1]The government does its best to deconstruct *Cromwell*, U.S. Brief at 15-17, but the fact remains that the Sixth Circuit's decision is squarely in conflict with the Eleventh Circuit's decision here. The government believes that *Travelers* has superseded Judge Suhrheinrich's concurring opinion in *Cromwell*, but the government badly misreads *Travelers*. *See infra* n.2.

at 551. As to the Fifth Circuit, the government claims that *Memorial Hospital Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990), distinguished *Hermann I*. U.S. Brief at 15 n.5. The government fails to cite *Hermann II*, in which the Fifth Circuit disavowed *Memorial Hospital* and reaffirmed the *Hermann I* holding that ERISA preempts a provider's negligent misrepresentation claim. 959 F.2d at 578.

The government also ignores that the confusion on this issue extends beyond the federal courts of appeal and state supreme courts. Several district courts in circuits that have not spoken on the issue have held that ERISA preempts provider common law claims. *See Barnes Hosp. v. Sanus Passport/Preferred Servs., Inc.*, 809 F. Supp. 725, 726-28 (E.D. Mo. 1992); *Psychiatric Inst. of Washington, D.C. v. Connecticut Gen. Life Ins. Co.*, 780 F. Supp. 24, 31-32 (D.D.C. 1992); *Northwestern Inst. of Psychiatry, Inc. v. Travelers Ins. Co.*, No. 92-1520, 1992 WL 236257 (E.D. Pa. Sept. 3 1992), *modified on other grounds*, 1992 WL 331521 (E.D. Pa. Nov. 3, 1992). Other district courts are aligned with the Eleventh Circuit. *See Rehabilitation Inst. of Chicago v. Group Administrators, Ltd.*, 844 F. Supp. 1275 (N.D. Ill. 1994); *Beth Israel Medical Center v. Sciuto*, No. 92 Civ. 8729 (RPP), 1993 WL 258636 (S.D.N.Y. July 8, 1993). Still others have reached mixed results. *See, e.g., Forest Springs Hosp. v. Illinois New Car & Truck Dealers Ass'n Employees Ins. Trust*, 812 F. Supp. 729, 731-33 (S.D. Tex. 1993) (negligent misrepresentation claim not preempted, but equitable estoppel claim preempted). Finally, some courts look to the nature of the alleged representations, and find preemption where the representations would have the effect of modifying the

terms of the ERISA plan, while denying preemption where the representations merely interpret ambiguous plan provisions or promise benefits in the absence of any coverage at all. *See Brown Schools, Inc. v. Florida Power Corp.*, 806 F. Supp. 146, 150-51 (W.D. Tex. 1992); *Parkside Lutheran Hosp. v. R.J. Zeltner & Assocs.*, 788 F. Supp. 1002 (N.D. Ill. 1992).

The existing disharmony among so many courts represents the worst possible situation, increasing confusion as to what laws apply, encouraging disputes and litigation and fostering inconsistent results. It is important that this chaos, which is bad for employers, providers and plan administrators alike, be resolved. Review in this case would allow the Court to eliminate all of this uncertainty.

2. Review also would allow this Court to reverse the Eleventh Circuit's erroneous ERISA preemption decision. The government defends that decision, but in so doing evinces the same misunderstanding of plan administration and the claims at issue that plagues the Eleventh Circuit's opinion. The government argues, for example, that the state law claim at issue here does not "relate to" an employee benefit plan because "[t]he cause of action for negligent misrepresentation under Georgia law does not refer to, and is not dependent on, the existence of an ERISA plan." U.S. Brief at 7. This is plainly incorrect. A claim of negligent misrepresentation presupposes that the defendant has misrepresented *something*. In this case, and others like it, the provider claims that the plan administrator misrepresented coverage under the plan. The cause of action refers to and is dependent on the plan.

Moreover, claims like that at issue in this case "relate to" employee benefit plans because they have a profound effect on plan administration. The government contends that these claims "ha[ve] no direct economic or administrative impact on the ERISA plan." U.S. Brief at 8. But the government is viewing each of these claims in a vacuum. Contrary to the government's position, provider suits do *not* represent "'one-time recovery [that] would not affect . . . on-going administration.'" *Id.* at 8 (quoting *Memorial Hospital*, 904 F.2d at 247). Plan administrators supply to providers information on plan coverage on a constant basis; the threat of state law claims arising from this vital aspect of plan administration is ever-present. If plan administration is to be wrenched from a uniform body of federal law and subjected to the vagaries of state tort litigation, with the possibility of uncontrollable punitive damages, administrators will adjust their provider interactions to take these costs into account. Administrators will be forced to take precautions that increase the cost of administration and make it more difficult for providers to assess quickly a patient's benefit plan coverage. These administrative changes will be felt by plan beneficiaries.[2]

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[2]The government argues that these are merely cost effects, and as such represent nothing more that "the type of indirect and purely economic impact on plans that *Travelers* held insufficient to trigger preemption." U.S. Brief at 8 n.1. This argument proves decidedly too much, for it would protect from ERISA preemption all state substantive regulation of plans, a result the *Travelers* Court plainly did not contemplate.

In *Travelers*, this Court held that ERISA generally does not preempt state laws that have only an indirect economic effect on employee benefit plans. 115 S. Ct. at 1680. State common law

claims like those at issue here are not merely economic regulation; they compel plan administrators to make substantive changes in plan administration. Ultimately, of course, the cost of these changes can be calculated in dollar terms; the "cost" of these claims translates to more expensive administration and medical care. But if these claims represent "purely economic" regulation, as the government contends, because adaptation means spending more money, *all* substantive requirements imposed on plans are purely economic regulation because compliance in all cases can be reduced to additional cost. By the government's reasoning, all such laws are thereby protected from ERISA preemption.

That result is obviously incorrect, and plainly contrary to this Court's authority. For example, the state law at issue in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), mandated that all health insurance policies provide coverage for mental health benefits. *Id.* at 727. From the perspective of an employee benefit plan purchasing health insurance, compliance with the law meant spending more money for the additional insurance coverage and the cost of administering the additional benefits. Despite the ultimately economic effect of the legislation, this Court had little difficulty concluding that the Massachusetts law "related to" employee benefit plans. *Id.* at 739. Regardless of its monetary impact, the law imposed real substantive requirements on the plan. The Court reaffirmed the *Metropolitan Life* holding in *Travelers*--noting that the Massachusetts law imposed a "substantive" requirement on plan administrators--even as it was declaring that purely indirect economic regulation is not preempted. 115 S. Ct. at 1680-81.

Like the mandatory benefit law at issue in *Metropolitan Life*, and unlike the hospital surcharges at issue in *Travelers*, common law misrepresentation and estoppel claims are more than mere economic regulation. They are substantive regulation that governs administrative practice and "relates to" employee benefit plans.

As the government correctly notes, ERISA establishes "a uniform set of regulations governing . . . procedures for processing claims and paying benefits." U.S. Brief at 10. This "comprehensive scheme," *id.* at 12, works ultimately to the advantage of beneficiaries by simplifying the environment for plan administration. ERISA occupies the field; where ERISA does not regulate a certain aspect of employee benefits, the area is to be free from regulation under both ERISA and state law. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983). The resulting "regulatory void" in certain areas evinces congressional intent to leave those subjects to the market and the discretion of plan administrators. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

State law claims of the sort at issue here threaten this scheme. ERISA preempts state misrepresentation and estoppel claims by plan beneficiaries, as the government concedes, leaving the resolution of disputes over benefits to the exclusive jurisdiction of ERISA and the terms of the plan. U.S. Brief at 12-14. The "regulatory void" for misrepresentation and estoppel claims represents a particular balance struck between the costs of this form of litigation and the possibility that some error, or claimed error, in supplying information might go unremedied. The purposes served by this exclusive regulatory scheme do not change when providers rather than beneficiaries sue. From the perspective of plan administration, provider inquiries and provider law suits impose the same costs as those involving beneficiaries. Because a provider law suit to recover "promised" plan benefits relates to an employee benefit plan every bit as much a similar suit by a beneficiary, ERISA strikes the same balance.

The government argues that provider suits can be distinguished from suits by beneficiaries because beneficiaries are held responsible under ERISA to know the terms of the plan, while providers are not. U.S. Brief at 14. Such a distinction undercuts entirely the ERISA scheme that holds beneficiaries to the terms of the plan, for provider suits allow beneficiaries an easy means for circumventing these requirements. According to the government (and the Eleventh Circuit), as long as the provider, rather than the beneficiary, calls the plan administrator to inquire about plan coverage, the terms of the plan no longer serve as a limitation on benefits available. This scenario provides yet another clear indication that provider suits "relate to" employee benefit plans.

In the end, the government cannot maintain the line it wishes to draw between the present claims and other preempted state regulation. The government claims that "misrepresentation claims raised by health care providers do not 'raise[] any issue concerning the matters that Congress intended to be regulated exclusively by ERISA,'" U.S. Brief at 9 (quoting *Memorial Hospital*, 904 F.2d at 247), while at the same time maintaining that preemption of provider claims "would directly undercut the interests of participants and beneficiaries" that constitute the purpose for which Congress enacted ERISA. *Id.* at 10. The government is (nearly) right the second time; provider suits very much affect plan administration and the interests of

plan participants and beneficiaries.[3] That is precisely why ERISA preempts such claims.

CONCLUSION

For the foregoing reasons, and those stated in the petition for writ of certiorari, this Court should grant the petition, set this case for plenary review, and reverse the judgment of the Eleventh Circuit.

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[3]The government also may be right that preemption of such suits ultimately works to the detriment of participants and beneficiaries. Perhaps the dramatic recent changes in health care administration have shifted the balance that ERISA strikes. Perhaps the opportunities for administrative misinformation have become so great that beneficiaries and providers should no longer have to bear the risk of these errors. The resulting inequity, if any, should be resolved by Congress, however, and not by filling the void with remedies under 50 different state laws.